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Commissioner



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TTY: Dial 711 (Maine Relay)

DATE: November 1, 2021

TO: Interested Parties

FROM: Michelle Probert, Director, MaineCare Services

A handwritten signature in black ink, appearing to read "Michelle Probert".

SUBJECT: **Adopted Rule:** Chapter 101, MaineCare Benefits Manual, Chapter II Section 97,
Private Non-Medical Institution Services

This letter gives notice of adopted rule: Chapter 101, MaineCare Benefits Manual, Chapter II, Section 97, Private Non-Medical Institution Services.

The Department of Health and Human Services (the "Department") adopts the following changes to 10-144 C.M.R. Ch. 101, MaineCare Benefits Manual (MBM), Chapter II, Section 97, Private Non-Medical Institution Services.

The Department adopts these rule changes to align Section 97 requirements with the Family First Prevention Services Act (FFPSA), which establishes standards for children's residential treatment programs in order to improve quality and oversight of services. The adopted changes are specific to Private Non-Medical Institution (PNMI) Appendix D Facilities, and are reflected in the definitions, eligibility for care, covered services and policies and procedures sections of this rule. Additionally, as directed under the FFPSA, the adopted rule includes requirements for Appendix D providers to meet Qualified Residential Treatment Programs (Q RTP) standards, which include obtaining and maintaining specified licensing and accreditation standards, as well as delivering trauma-informed treatment.

For compliance with the FFPSA related to improving quality and oversight of services, the Department amended Appendix D language referring to Child Care Facility Services and Models of Child Care Facilities, to be replaced with the term, "Children's Residential Care Facilities" (CRCFs). The adopted rule distinguishes models of residential care that address specific treatment needs of different member populations. CRCF models include Intellectual Disabilities/Developmental Disabilities (ID/DD-CRCF), Mental Health (MH-CRCF), Crisis Stabilization (CS-CRCF), and Child and Adolescent Therapeutic Foster Care. This rule further adopts amended language referring to "Intensive Temporary Residential Treatment Services" by replacing this with the term "Temporary High Intensity Services" and including language clarifying the covered services while also establishing the requirement for a Prior Authorization process.

The rule also adopts the use of Department-approved, age appropriate Level of Care/Service Intensity tools, which is required as a component of eligibility determination for ID/DD, MH, and CS CRCFs. The Level of Care/Service Intensity tools replace outdated instruments, to include the Child and Adolescent Functional Assessment Scale (CAFAS), the Children's Global Assessment Scale (C-GAS), the Global Assessment Functioning (GAF), and the Children's Habilitation Assessment Tool (CHAT); and streamline the process by utilizing one tool that is evidence based and clinically appropriate by age, to include the Early Childhood Service Intensity Instrument (ECSII), the Child and Adolescent Level of Care/Service Intensity Utilization

System (CALOCUS-CASII) and the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).

Additionally, this rule adopts various new covered services, including Aftercare Support Services, which are designed to promote a continuation of treatment gains with the goal of supporting the child in their home and community environment, and must be provided to youth for at least six (6) months post discharge from MH and ID/DD-CRCFs. The Department is additionally requiring a new position, a Family Transition Specialist (FTS), to aid in the delivery of aftercare and transition services for the youth and family.

To further align with the FFPSA to achieve improved quality and oversight of services, this adopted rule clarifies Appendix D requirements for the CRCF assessment, Individual Treatment Plan, progress notes, and discharge summary as well as adding various new defined terms.

The Department additionally adopted language that requires providers operating under Appendix D and Adolescent Residential Rehabilitation Services operating under Appendix B, to demonstrate utilization of the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) System of Care Principles. The rule requires delivery of trauma-informed care through the completion of a Trauma-Informed Agency Assessment, staff training and incorporation of these principles into program policy and procedures.

The Department also adopts specific requirements regarding background checks for providers operating under Appendix D and Adolescent Residential Rehabilitation Services providers operating under Appendix B. Children's residential facility providers must follow the requirements set forth in 22 M.R.S. § 8110 and 42 U.S.C. § 671(20). Behavioral Health Services providers must conduct background checks every five (5) years and fingerprinting. The adopted rule requires completed background checks for all staff and all adults providing services to a member within ninety (90) days of the effective date of this rule and that all background checks are to be completed every five (5) years thereafter.

The Department further adopts, under Appendix D, the addition of Behavioral Health Professionals (BHP) and Family Transitional Specialists (FTS) as Other Qualified Residential Treatment Facility Staff as well as including Board Certified Behavior Analyst services, Registered Behavior Technician services and Board Certified Assistant Behavior Analyst services. The Department is requiring confirmation that prospective BHPs are not annotated in the registry (per 10-144 C.M.R. ch. 128, Certified Nursing Assistant and Direct Care Worker Registry Rule) prior to qualifying as a staff member under this rule.

In addition to the above adopted changes, the Department adopted language increasing access to necessary services by removing the 'single admission' limitation and increasing the number of allowable covered days for Halfway House and Extended Care Services under PNMI Appendix B of this rule. The Department also adopted edits to language to accurately reflect current practices as well as updates to formatting, citations, and references where necessary, including changes to address potentially stigmatizing language based on recommendations from Maine's opioid task force and legislation passed in 2018 to minimize stigma (P.L. 2017, ch. 407).

The Department shall seek CMS approval for the new covered services and provider requirements, as specifically noted in various adopted rule changes.

In addition, the Department intends to implement corresponding changes as needed in the MBM, Chapter III, Section 97, to ensure adequate reimbursement for providers to deliver all new covered services and meet QRTP standards and other Chapter II-related updates. For example, Chapter III Appendix D Sec. 2400.1 must be updated in order to ensure that rates cover the costs of Board Certified Behavior Analysts and the other new types of direct service staff. The Chapter III, Section 97 rule is major substantive, and the

upcoming changes shall be filed as an emergency rule no later than Nov. 1, 2021, so that they will be effective at the same time the changes in Chapter II, Section 97 are finally adopted.

Considering public comment and legal advice from the Office of Attorney General, the Department made various changes to the final rule from what was proposed.

Changing requirements for Appendix D providers, service delivery, and provisions of treatment to provide more specificity and allow for more flexibility for providers, include:

- Updating language related to accreditation under 97.07-2(F)(h)(2) to allow for accreditation to be completed within 12 months.
- Extending the Prior Authorization for Temporary High Intensity Services (97.02-5(C)) from a seven (7) day authorization to “up to thirty (30) days.”
- Including language under 97.08-2.G(6) to address exemptions related to Aftercare Support Services.
- Adding language under 97.06-3 (Non-Reimbursable Days), to include, “Members receiving services in an emergency department are exempt from this provision when emergency treatment is sought at 8:00pm or later and the member returns to the facility the following day.”
- Removing references that limit telehealth services and reducing the frequency of required in-person contact for Aftercare Support Services.
- Clarifying that both ITPs and FBAs are reviewed minimally every thirty (30) days.
- Updating language, under 97.08-2(C)(2), to include more flexibilities for behavioral and/or rehabilitative therapies.
- Clarifying language related to family involvement in treatment under Appendix D CRCFs to include more involvement by the Department’s Office of Child and Family Services (OCFS) and specific requirements.

Changing requirements for Appendix D CRCF staff include:

- Allowing for, under 97.07-2(H)(3), a bachelor’s degree in an unrelated field with at least one (1) year of related professional experience, and extending time for staff to obtain BHP certification for new hires to six (6) months from the date of hire and staff currently employed to one (1) year from the effective date of the rule.
- Updating CRCF staff supervision requirements to include a minimum of three (3) hours per month includes one (1) hour of individual and one (1) hour of clinical supervision conducted by a Clinician as defined in 97.01-4.

All changes are specifically listed in the separate document, Summary of Comments and Responses and List of Changes to the Final Rule.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare website at <http://www.maine.gov/dhhs/oms/rules/index.shtml> or, for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or Maine Relay number 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at <http://www.maine.gov/sos/cec/rules/notices.html>. This notice also provides information regarding the rulemaking process. Please address all comments to the agency contact person identified in the Notice of Agency Rulemaking Proposal.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual (MBM), Chapter II, Section 97, Private Non-Medical Institution Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY:

The Department of Health and Human Services (the “Department”) adopts the following changes to 10-144 C.M.R. Ch. 101, MaineCare Benefits Manual (MBM), Chapter II, Section 97, Private Non-Medical Institution Services.

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The Department shall seek CMS approval for the new covered services and provider requirements, as specifically noted in various adopted rule changes.

In addition, the Department intends to implement corresponding changes as needed in the MBM, Chapter III, Section 97, to ensure adequate reimbursement for providers to deliver all new covered services and meet QRTP standards and other Chapter II-related updates. For example, Chapter III Appendix D Section 2400.1 must be updated in order to ensure that rates cover the costs of Board Certified Behavior Analysts and the other new types of direct service staff. The Chapter III, Section 97 rule is major substantive, and the upcoming changes shall be filed as an emergency rule no later than Nov. 1, 2021, so that they will be effective at the same time the changes in Chapter II, Section 97 are finally adopted.

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All changes are specifically listed in the separate document, Summary of Comments and Responses and List of Changes to the Final Rule.

See <http://www.maine.gov/dhhs/oms/rules/index.shtml> for rules and related rulemaking documents.

EFFECTIVE DATE:	November 1, 2021
AGENCY CONTACT PERSON:	Melanie Miller, Comprehensive Health Planner II Melanie.Miller@maine.gov
AGENCY NAME:	MaineCare Services
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MAINECARE BENEFITS MANUAL
Chapter II

Section 97	PRIVATE NON-MEDICAL INSTITUTION SERVICES	ESTABLISHED: 1/1/85 LAST UPDATED: 11/1/21
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*The Department of Health and Human Services is in the process of replacing all references to the term “substance abuse” throughout all of its rules to reflect current and appropriate terminology per P.L. 2017, Ch. 407, Part B, Sec. B-1. The Department has replaced the term “substance abuse” with “substance use” throughout the text of this rule, and anticipates doing the same when the corresponding Chapter III, Section 97, Appendices, and licensing rules are next open to rulemaking. These updates in terminology should not be construed in any way as affecting the services outlined in this policy.

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PRIVATE NON-MEDICAL INSTITUTION SERVICES

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97.01 DEFINITIONS

97.01-1 Aftercare Support Services*

Aftercare Support Services are individualized family-focused, community-based, trauma-informed, culturally sensitive services that will be provided for at least six (6) months post discharge and meet all criteria as defined in Section 50741 of the federal Family First Prevention Services Act (H.R. 1892).

Aftercare Support Services are interventions for members receiving Intellectual Disabilities/Developmental Disabilities (ID/DD) and Mental Health (MH) Children's Residential Care Facility (CRCF) services under Appendix D.

***The Department shall seek CMS approval for these services.**

97.01-2 Authorized Entity

Authorized Entity is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions for the Department pursuant to a signed contract or other approved signed agreement, including but not limited to conducting prior authorization, clinical review, and concurrent review of services.

97.01-3 Caregiver

Caregiver is an individual who is responsible for the custodial care and protective oversight and supervision of a child/youth. Caregivers may include, but are not limited to, a member's parent(s), immediate or extended family, foster parent(s) temporarily assigned by the Department, other natural supports fulfilling this role, or professional staff providing protective oversight and supervision in a variety of settings.

97.01-4 Clinician

Clinician is an individual appropriately licensed or certified in the state or province in which they practice, practicing within the scope of that licensure or certification, and qualified to deliver treatment under this Section. A clinician includes the following: licensed clinical professional counselor (LCPC); licensed clinical professional counselor-conditional (LCPC-conditional); licensed clinical social worker (LCSW); licensed master social worker-conditional clinical (LMSW-conditional clinical); licensed marriage and family therapist (LMFT); licensed marriage and family therapist-conditional (LMFT-conditional); licensed alcohol and drug counselors (LADC); physician; psychiatrist; advanced practice registered nurse psychiatric and mental health practitioner (APRN-PMH-NP); advanced practice registered nurse psychiatric and mental health clinical nurse specialists (APRN-PMH-CNS); psychological examiner; physician's assistant (PA); registered nurse or licensed clinical psychologist.

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97.01 DEFINITIONS (cont.)

97.01-5 Family

Unless defined otherwise in the Principles of Reimbursement of Chapter III, Section 97, family means any of the following: spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative.

97.01-6 Functional Behavior Assessment (FBA)

A process of gathering information from multiple sources to hypothesize and understand what reliably predicts and maintains a problem behavior. The FBA evaluates behavior to analyze the antecedent and consequence as a reinforcement of a problem behavior. Behaviors are defined in measurable terms. The FBA uses a validated assessment which may also include interview, direct and/or indirect observation in the member's natural environment, functional analysis, preference assessment, assessment of reinforcement effectiveness, data collection, and reporting. The FBA will be used for the purpose of developing individualized Positive Behavior Support Plans (97.01-13) for members receiving for members receiving ID/DD CRCF services under Appendix D.

97.01-7 Individual Service Plan/Individual Treatment Plan

An Individual Service Plan (ISP) or Individual Treatment Plan (ITP) means the plan of service and/or treatment based on an individual assessment of a member's need for treatment or rehabilitation services made in accordance with the appropriate Principles of Reimbursement. Unless otherwise specified in the appropriate Principles of Reimbursement, this plan shall specify the service and/or treatment components to be provided, the frequency and duration of each service/treatment component, and the expected short and long range treatment and/or rehabilitative goals or outcome of services/treatment. Discharge planning must be addressed in the Individual Service Plan/Individual Treatment Plan.

97.01-8 Interim Per Diem

A per diem rate is the rate determined by the Department of Health and Human Services (DHHS) (per Chapter III, Principles of Reimbursement for PNMI, Section 2400 and the applicable Appendix) that may be paid to a PNMI provider for the provision of covered services on an interim basis prior to calculation of the Per Diem Rate.

97.01-9 Medical Eligibility Determination (MED) Tool

Medical Eligibility Determination (MED) Tool means the form approved by the Department for medical eligibility determinations and service authorization

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97.01 DEFINITIONS (cont.)

for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms and timeframes relating to this form are outlined in Chapter II, Section 96.02-4.

97.01-10 Medical Supplies and Durable Medical Equipment

Unless defined otherwise in the Principles of Reimbursement, medical supplies and durable medical equipment means medically necessary supplies and equipment listed in Chapter II, Section 60, Medical Supplies and Durable Medical Equipment of the *MaineCare Benefits Manual* (MBM). All equipment must be directly related to member medical needs as documented in the individual service plan.

97.01-11 Natural Supports

Individuals who do not share a common residence with the child and their family, and who include the relatives, friends, neighbors, and community resources that a child and/or their family go to for support.

97.01-12 Per Diem Rate

A per diem rate is the rate determined by the Department of Health and Human Services (DHHS) (per Chapter III, Principles of Reimbursement for PNMI, Section 2400 and the applicable Appendix) paid to a PNMI provider for the provision of covered services.

97.01-13 Positive Behavior Support Plan (PBSP)

A Positive Behavior Support Plan includes individualized, strengths-based strategies based on positive reinforcement techniques that are designed to increase a member's use of prosocial and positive behaviors and decrease negative or detrimental behaviors. The PBSP will summarize the findings of the Functional Behavioral Assessment, and be used for the purpose of developing individualized strategies for members receiving ID/DD CRCF services under Appendix D.

97.01-14 Prior Authorization

Prior Authorization (PA) is the process of obtaining prior approval as to the medical necessity and eligibility for a service. Prior Authorization is also detailed in Chapter I of the *MaineCare Benefits Manual* (MBM). Crisis stabilization services do not require prior authorization, but providers must contact the Department within 48 hours to complete the prior authorization process for reimbursement of continued services. Other PNMI services require prior authorization as detailed in this Section.

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97.01 DEFINITIONS (cont.)

97.01-15 Private Non-Medical Institution

A Private Non-Medical Institution (PNMI) is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, personal care, and treatment services to four (4) or more residents in single or multiple facilities or scattered site facilities. Private Non-Medical Institution services or facilities must be licensed by the Department of Health and Human Services or must meet comparable licensure standards and/or requirements and staffing patterns as determined by the Department specified in Section 97.01 (B-F). For agencies serving persons with intellectual disabilities/developmental disabilities (ID/DD) in scattered site PNMI, comparable licensure standards means those required by rule for community support services as described in Mental Health Agency Licensing Standards, the Rights of Recipients of Mental Health Services, and Regulations for Licensing and Certification of Alcohol and Drug Treatment Services.

Services provided out-of-state must be medically necessary and unavailable in the State of Maine, and may be subject to approval by the Commissioner of the Department of Health and Human Services or designee, as well as prior authorization, as described in this Section and Chapter I of the *MaineCare Benefits Manual*. The following details those services in Chapter III, Section 97:

Appendix B. Substance Use Treatment Facility

A substance use treatment facility is a PNMI that is maintained and operated for the provision of residential substance use treatment and rehabilitation services and, with the exception of facilities providing Adolescent Residential Rehabilitation Services, is licensed and funded by the Department's Office of Behavioral Health.

A substance use treatment facility providing Adolescent Residential Rehabilitation Services shall be maintained and operated for the provision of treatment and care for one or more children on a regular basis, and shall be considered a "Children's Residential Care Facility" as defined in 22 M.R.S. § 8101(4). Appendix B providers of Adolescent Residential Rehabilitation Services shall be licensed by the Department, Office of Child and Family Services, under the "Children's Residential Care Facilities Licensing Rules," 10-144 CMR Chapter 36.

Substance use treatment facilities are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix B.

97.01 DEFINITIONS (cont.)

Appendix C. Medical and Remedial Services Facility

Medical and remedial services facilities are those facilities as defined in 22 MRSA §7801 that are maintained wholly or partly for the purpose of providing residents with medical and remedial treatment services and licensed by the Department of Health and Human Services under the "Regulations Governing the Licensing and Functioning of Assisted Living Facilities." These facilities must also be qualified to receive cost reimbursement for room and board costs not covered under this Section.

Medical and remedial facilities are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix C.

Appendix D. Children's Residential Care Facilities (CRCFs)

A children's residential care facility is any private or public agency or facility that is maintained and operated for the provision of treatment and care for one or more children on a regular basis, as defined in 22 MRSA §§ 8101, 8101(1), and 8101(4), is licensed by the Department of Health and Human Services under the "Children's Residential Care Facilities Licensing Rules," 10-144 CMR, Chapter 36; and/or is licensed by the Department's Office of Child and Family Services pursuant to 22 MRSA §§ 7801 and 8104.

CRCFs include four (4) models of service delivery:

1. Intellectual Disabilities/Developmental Disabilities (ID/DD-CRCF),
2. Mental Health (MH-CRCF),
3. Crisis Stabilization (CS-CRCF), and
4. Child and Adolescent Therapeutic Foster Care.

For the purpose of MaineCare reimbursement only, Children's Residential Care Facilities also include treatment foster homes, their staff and parents, licensed by the Department, and child placing agencies under contract with the Office of Child and Family Services. Child placing agencies must be licensed in accordance with 10-148 CMR Chapter 19-A, Rules for the Licensure of Private Non-Medical Institutions-Child Placing Agencies with and Without Adoption Programs. Children's Residential Care facilities are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix D.

97.01 DEFINITIONS (cont.)

Appendix E. Community Residences for Persons with Mental Illness

A community residence PNMI is a PNMI with integral mental health treatment and rehabilitative services, that is licensed by the Department, overseen as a mental health residential treatment or supportive housing service by the Office of Behavioral Health, and operated in compliance with treatment standards established through these rules and the pertinent Principles of Reimbursement.

Community residences for persons with mental illness also include residential services for the integrated treatment of persons with dual disorders, which provide mental health and substance use treatment services to individuals with coexisting disorders of mental illness and substance use. These residences shall be licensed by the Department. Such residences must also be receiving funds from the Department for the treatment of persons with dual disorders. Community residences for persons with mental illness are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix E.

Appendix F. Non-Case Mixed Medical and Remedial Facilities

Non-case mixed facilities provide PNMI medical and remedial treatment services to members in specialized facilities or scattered site facilities not included in the case mix payment system described in Appendix C. These facilities specialize in solely treating members with specific diagnoses such as acquired brain injury, HIV/AIDS, ID/DD, or blindness. Services must be provided in compliance with these rules, the pertinent MBM Chapter III, Section 97, Chapter III, Section 97 Appendix F, and any contractual provisions of the Department.

97.01-16 Private Non-Medical Institution Services

Private Non-Medical Institution services are those services provided to a member at one of the above properly licensed and/or designated institutions, in accordance with these regulations, and in accordance with the pertinent Principles of Reimbursement established by the Department of Health and Human Services.

97.01-17 Program Allowance

A program allowance, expressed as a percentage of the allowable costs, as defined in Chapter III, Section 97, Sections 2400.1 and 2400.2 may be allowed

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97.01 DEFINITIONS (cont.)

in lieu of indirect and/or PNMI related cost. See applicable Chapter III section and appendix.

97.01-18 Provider Agreement

A provider agreement encompasses the MaineCare Provider Agreement on file with the Office of MaineCare Services. Providers must also contract with the Department and satisfactorily meet all contract and provider agreement provisions.

97.01-19 Qualified Residential Treatment Program (QRTP)*

A Qualified Residential Treatment Program (QRTP) is a federal designation for a children's residential care facility that meets all standards as defined in Section 50741 of the federal Family First Prevention Services Act, Pub. Law 115-123, Div. E, Title VII (2018)(the "Family First Prevention Services Act"). QRTPs shall have a trauma-informed treatment model designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances. All MH and ID/DD CRCFs, under Appendix D, are required to meet QRTP standards.

***The Department shall seek CMS approval for these changes.**

97.01-20 Rate Letter

A rate letter is an instrument used to inform the provider of the approved total cost cap and per diem rate based on a review of the submitted budget per Chapter III, Section 2400, General Provisions. For case mix facilities covered under Appendix C, the rate letter informs the agency of the industry price, program allowance, personal care services component, and average case mix index.

97.01-21 Serious Emotional Disturbance (SED)

For members under the age of twenty-one (21), SED is a condition in which a member has a mental health and/or a co-occurring substance use disorder diagnosis, emotional or behavioral diagnosis, under the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), that has lasted for or can be expected to last for at least one (1) year, and is at risk for more restrictive placement, including but not limited to, psychiatric hospitalization, as a result of this condition for which other less intensive levels of service have not been effective (e.g. traditional outpatient services).

97.01 DEFINITIONS (cont.)

97.01-22 Utilization Review

Utilization Review (UR) is a formal assessment of the medical necessity, efficiency and appropriateness of services and treatment plans on a prospective, concurrent, or retrospective basis.

97.02 ELIGIBILITY FOR CARE

97.02-1 General Eligibility Criteria

The following individuals are eligible for medically necessary covered Private Non-Medical Institution services as set forth in this Manual:

Individuals must meet the basic eligibility criteria as set forth in Part 2 of the *MaineCare Eligibility Manual*, 10-144 CMR Chapter 332. There are restrictions on the type and amount of services that members are eligible to receive and they must meet specific eligibility criteria detailed below.

97.02-2 Medical Necessity

Services in PNMI's must be medically necessary, as evidenced by meeting the medical eligibility criteria set forth in this section. A physician or primary care provider must also document in writing that this model of service is medically necessary for the member, and both the physician and the PNMI provider must keep this documentation in the member's file. For all PNMI services, this documentation must be completed as part of the prior authorization process conducted by the Department and/or its Authorized Entity.

97.02-3 Medical Eligibility for Appendix B: Substance Use Facilities

Members must require residential substance use treatment as assessed by the provider and documented in the individual service plan and member's file using the most current edition of the American Society of Addiction Medicine's, ASAM Criteria: Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions, Level III, Residential/Inpatient Treatment Criteria. Members must continue to meet Level III for continued eligibility.

The Department or its Authorized Entity will conduct utilization review to assure medical necessity of these services.

97.02-4 Prior Authorization and Medical Eligibility for Appendix C: Medical and Remedial Facilities

Appendix C facilities must contact the Department's Office of Aging and Disability Services, who must verify that members meet the medical eligibility

97.02 ELIGIBILITY FOR CARE (cont.)

requirements for residential care as indicated by the Medical Eligibility Determination (MED) tool assessment.

A member meets the medical eligibility and admission criteria for Appendix C PNMI only if that person meets one (1) or more of the following eligibility requirements:

- Requires cuing seven (7) days per week for eating, toilet use, bathing, and dressing; OR
- Requires limited assistance and a one (1) person physical assist with at least two (2) of the seven (7) activities of daily living (ADLs) including bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing; OR
- Requires preparation and administration of regularly scheduled prescribed medications two (2) or more times per day that is or otherwise would be performed by a person legally qualified to administer prescribed medications; OR
- Requires any of the following nursing services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described below:
 - administration of treatments, procedures, or dressing changes which involve prescribed medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring. These treatments include:
 - administration of medication via a tube;
 - tracheostomy care;
 - urinary catheter change;
 - urinary catheter irrigation;
 - barrier dressings for Stage 1 or 2 ulcers;
 - chest Physical Therapy (PT) by RN;
 - oxygen therapy by RN; or
 - other physician-ordered treatments; OR
- Professional nursing assessment, observation, and management for problems including wandering, physical or verbal abuse or socially inappropriate behavior; OR
- Professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability; OR

97.02 ELIGIBILITY FOR CARE (cont.)

- Exhibits moderately to significantly impaired decision-making ability that will result in reasonably foreseeable unsafe behavior when not appropriately supervised as measured by the cognition section of the MED tool; OR
- Presents an imminent risk of harm or a probable risk of significant deterioration, as determined by the Department or the Department's Authorized Entity, of the individual's physical, mental or cognitive condition if the individual resides or would reside outside of a licensed facility.

97.02-5 General Eligibility, Specific Eligibility, Prior Authorization, and Continued Stay Requirements for Appendix D Children's Residential Care Facilities (CRCFs)

A. General Eligibility Criteria

To be eligible for children's CRCF services, except Therapeutic Foster Care, members must meet all the following criteria:

1. Be under the age of twenty-one (21);
2. Have consent, when applicable, from their parent or legal guardian to receive this service, as documented through the parent or legal guardian's signature on the applicable referral and CRCF application forms, as well as any forms/consents that the facility requires;
3. Have been assessed by a Clinician (as defined in 97.01-4) within the past six (6) months, with annual reassessment required, to meet the criteria for one (1) or more of the following:
 - a. The member is under the age of twenty-one (21) and has an active psychiatric condition and functional deficits qualifying as a Serious Emotional Disturbance (SED) meeting the criteria below:
 - i. The member has a primary diagnosis, listed in Table I of this rule, with a severity specifier of moderate to severe (when applicable) when applied to the current condition of the youth, as determined by a Clinician, for the previous six (6) month period or reasonably predicted to last six (6) months;
 - ii. The member consistently and persistently demonstrates behavioral abnormalities to a significant degree not attributable to intellectual, sensory, or health factors and well outside the normative developmental expectations, for the

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previous six (6) month period or reasonably predicted to last six (6) months; and

iii. The member additionally displays, at a minimum, four (4) of the following conditions:

1. failure to establish or maintain developmentally appropriate relationships with adult caregivers or authority figures;
2. failure to demonstrate or maintain developmentally appropriate peer relationships;
3. failure to demonstrate a developmentally appropriate range and expression of emotion or mood;
4. disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic, or recreation settings; and
5. behavior that is seriously detrimental to the youth's growth, development, safety, or welfare, or to the safety or welfare of others; or behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment; or

b. Diagnosis of Intellectual Disability (Intellectual Developmental Disorder) based on the most current version of the DSM; or

c. Diagnosis of Autism Spectrum Disorder based on the most current version of the DSM;

4. Have a result from a Department approved, age appropriate Level of Care/Service Intensity tool which indicates the need for residential level of care, completed by the Department or its Authorized Entity prior to admission and at ongoing intervals determined by the Department. The appropriate tools include, but are not limited to:

- a. Early Childhood Service Intensity Instrument (ECSII) for ages zero (0) to five (5);
- b. Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) for ages six (6) to eighteen (18); and

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- c. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) for ages eighteen (18) to twenty-one (21); and
- 5. Have clinical documentation that current treatment needs cannot be met by a lower level of care within home and/or community settings. Documentation must show that the member's functioning has not significantly improved using outpatient or home and community-based treatment models over the prior two (2) to six (6) months as evidenced by one (1) or more of the following:
 - a. The member cannot be safely maintained at home or in the community due to documented risk of harm to self and/or others; or
 - b. The member demonstrates persistent, serious, disruptive and/or defiant behavior, aggression, and/or impulsivity related to their diagnosis and this behavior is observed and documented to negatively impact the member's functioning in at least two (2) of the following settings: home, school/work, and/or community; or
 - c. The member demonstrates chronic truancy, is at increased risk for expulsion, suspension, and/or is involved with the juvenile justice system.

B. Specific Eligibility Criteria

- 1. To be eligible for ID/DD CRCF services, as defined in 97.08-1 (A) (1), members must meet all the following criteria:
 - a. General eligibility criteria above (97.02-5 (A)), and
 - b. The member is assessed with the most current version of the Vineland Adaptive Behavior Scale or the Adaptive Behavioral Assessment Scale, or other tools as authorized by the Department, administered within six (6) months prior to the date of the referral documenting:
 - i. Functional impairment measured as two (2) standard deviations below the mean on the composite score; or
 - ii. Functional impairment measured as one point five (1.5) standard deviations below the mean on the composite score and two (2) standard deviations below the mean in the communication or social domain sub score of the most recent version of the assessment tool.

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97.02 ELIGIBILITY FOR CARE (cont.)

2. To be eligible for Child and Adolescent Therapeutic Foster Care services, members must meet all of the following criteria:
 - a. Be in DHHS or Department of Corrections custody;
 - b. Require therapeutic intervention detailed in 97.08-2 (A) (4);
 - c. Have a Child and Adolescent Functional Assessment Scale (CAFAS) eight (8) scale score of fifty (50) or higher;
 - d. Have a diagnosis from the most current version of the DSM within the last six (6) months;
 - e. Have a disorder that has lasted for at least six (6) months or is expected to last for at least one (1) year in the future;
 - f. Have current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four (24) hour basis; and
 - g. Be at significant risk of hospitalization even with intensive community intervention, including services and supports, or there is a clear indication that the child's condition would significantly deteriorate and would require a higher model of service than can be provided in the home and community.

C. Prior Authorization

- i. MH and ID/DD CRCF services under Appendix D require prior authorization by the Department or its Authorized Entity.

Referring providers must submit all required documentation to include:

1. Physician's letter within the last sixty (60) days explaining clinical rationale and medical necessity for residential treatment;
2. Most recent Functional Assessment Score (if applicable);
3. Most recent Level of Care/Service Intensity Tool Score; and
4. Any additional information as requested by the Department or its Authorized Entity to include, but not limited to, the following evaluations, assessments, and reports:
 - a. current clinical recommendations;

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97.02 ELIGIBILITY FOR CARE (cont.)

- b.
 - c. psychological/psychiatric/educational services, including Full Scale Intelligence Quotient (FSIQ) score;
 - d. activities of daily living;
 - e. crisis services;
 - f. hospitalizations;
 - g. child welfare and/or criminal justice involvement; and
 - h. incident reports.
- ii. Temporary High Intensity Services (THIS) require prior authorization from the Department or its Authorized Entity. This service may be authorized for up to thirty (30) days per authorization period.

CRCF providers must submit all required documentation to include:

1. The clinical rationale for the member's need for increased intensity of service;
2. A detailed summary of the interventions attempted by the CRCF to reduce the member's acuity;
3. A detailed plan for how the increased intensity will be used to meet the member's needs; and
4. How the service will be reduced as the member improves.

In situations where THIS are requested for more than thirty (30) days, the Department or its Authorized Agent, in coordination with the treatment team, shall consider if a higher level of care is appropriate for the member.

Failure to submit requested information may result in denial of the Prior Authorization request. The Department will not reimburse for services that have not been prior approved.

- iii. Crisis Stabilization CRCF providers must contact the Department within forty-eight (48) hours of initiation of service to begin the Prior Authorization process for continued provision of services.

D. Continued Stay Requirements

MH and ID/DD CRCF services require Utilization Review up to every ninety (90) days of treatment. The Department or its Authorized Entity will evaluate effectiveness before authorizing continuation of treatment. Utilization Review must ensure that:

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97.02 ELIGIBILITY FOR CARE (cont.)

1. The ITP is reviewed minimally every thirty (30) days;
2. Each member has a medical need for the service;
3. The member's parent/caregiver is participating in the treatment planning process and in the treatment, if appropriate;
4. Measurable progress is being made on the goals and objectives identified in the ITP and that progress is expected to continue; and
5. A discharge plan addresses the natural supports and treatment needs that will be necessary for the member and family to sustain their progress at the end of this treatment.

97.02-6 Prior Authorization and Medical Eligibility for Appendix E: Community Residences for Persons with Mental Illness

Appendix E services require prior authorization and utilization review.

Providers must submit all eligibility documentation required for prior authorization according to the guidelines of this Section and Chapter I of the *MaineCare Benefits Manual* to the Office of Behavioral Health. No PNMI provider may admit a member into an Appendix E facility without prior authorization. To be eligible, members must meet the following eligibility criteria, with documentation of all of the following information in the member's care plan:

a. Assessment Tools Used for Prior Authorization

Providers must use the most current edition of the Department's approved assessment tool, the Level of Care Utilization System for Psychiatric and Addiction Services, of the American Association of Community Psychiatrists (LOCUS) as a tool in assessing eligibility.

b. Eligibility Criteria

Members must meet the following eligibility criteria, with documentation of all of the following information in the member's plan:

The person is age eighteen (18) or older or is an emancipated minor;

AND

Has a primary diagnosis in accordance with the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, other than one of the following diagnoses: Delirium, dementia, amnesia, and other

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cognitive disorders; Mental disorders due to a general medical condition, including neurological conditions and brain injuries; Substance use or dependence; developmental disabilities; Adjustment disorders; V-codes; or Antisocial personality disorder;

AND

demonstrates a need for residential care as assessed by the LOCUS with a score on the LOCUS of at least 23 or greater or a Level V or more.

97.02-7 Prior Authorization and Medical Eligibility Criteria for Appendix F: Non-Case Mixed Facilities

Non-Case Mixed Medical and Remedial Facilities specialize in the treatment of adults with ID/DD, brain injury, mental illness, or other disabilities.

No PNMI provider may admit a member into an Appendix F mental health facility without prior authorization. Appendix F Non-Case Mixed facilities must contact the Department of Health and Human Services as detailed below to obtain prior authorization for services:

Those facilities serving public wards must contact the Office of Aging and Disability Services Adult Protective Services Regional Offices for authorization for placement of any member in an Appendix F facility serving public wards. For all other Appendix F facilities contact the Office of Aging and Disability Services to assure that services are prior authorized.

1. Medical Eligibility Criteria for Persons Treated in Facilities Specializing in Treatment of Mental Illness

Facilities serving members with mental illness in an Appendix F facility must submit all eligibility documentation required for prior authorization according to the guidelines of this Section and Chapter I of the *MaineCare Benefits Manual* to the DHHS Office of Behavioral Health. To be eligible, members must meet the following eligibility criteria, with documentation of all of the following information in the member's care plan:

- a. **Assessment Tools Used for Prior Authorization**
Providers must use the most current edition of the Department's approved assessment tool in assessing eligibility, the LOCUS, which is the Level of Care

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97.02 ELIGIBILITY FOR CARE (cont.)

Utilization System for Psychiatric and Addiction Services
of the American Association Services.

b. Eligibility Criteria

Members must meet the following eligibility criteria,
with documentation of all of the following information
in the member's plan:

The person is age eighteen (18) or older or is an
emancipated minor;

AND

Has a primary diagnosis in accordance with the most current
version of the *Diagnostic and Statistical Manual of Mental
Disorders (DSM)*, other than one of the following diagnoses:
Delirium, dementia, amnesia, and other cognitive disorders;
Mental disorders due to a general medical condition, including
neurological conditions and brain injuries; Substance use or
dependence; developmental disabilities; Adjustment disorders;
V-codes; or Antisocial personality disorder;

AND

demonstrates a need for residential care as assessed by
the LOCUS with a score on the LOCUS of at least 23 or
greater or a Level V or more.

**2. Medical Eligibility Criteria for Persons Treated in Facilities
Specializing in Treatment of Brain Injuries**

To be eligible for services in facilities specializing in treatment
of brain injury, members must meet the following eligibility
criteria, with documentation of all of the following information
in the member's individual service plan:

The person must be age eighteen (18) or older AND

Have a primary diagnosis of head injury, defined as "an insult to
the brain resulting directly or indirectly from trauma, anoxia,
vascular lesions or infection, which is not of a degenerative or
congenital nature; can produce a diminished or altered stated of
consciousness resulting in impairment of cognitive abilities or
physical functioning; can result in the disturbance of behavioral

97.02 ELIGIBILITY FOR CARE (cont.)

or emotional functioning; can be either temporary or permanent; and can cause partial or total functional disability or psychosocial maladjustment” confirmed by a qualified neuropsychologist or a licensed physician who is Board certified or otherwise Board eligible, in either physical medicine and rehabilitation or neurology;

AND

Have cognitive, physical, emotional and behavioral needs resulting in a score of at least three (3) on one item in at least two (2) domains on the Brain Injury Assessment Tool (BIAT) administered by a qualified neuropsychologist or occupational therapist or speech/language pathologist or a licensed physician who is Board certified or otherwise Board eligible in either physical medicine and rehabilitation or neurology or other licensed professional authorized by Brain Injury Services;

AND

Have a demonstrated need for twenty-four (24) hour supervision and support as indicated on the Brain Injury Health and Safety Assessment (BIHSA) administered by a qualified neuropsychologist or occupational therapist or speech/language pathologist or a licensed physician who is Board certified or otherwise Board eligible in either physical medicine and rehabilitation or neurology or other licensed professional authorized by Brain Injury Services.

Members with brain injuries receiving these services will be reassessed annually using the BIAT and BIHSA to determine continuing need for services.

Members no longer eligible for these services will be discharged only to a safe, appropriate residential arrangement.

3. Medical Eligibility Criteria for Persons Treated in Facilities Specializing in Treatment of Members with Intellectual Disabilities/ Pervasive Developmental Disorder

In order to be eligible for services under this sub-section specializing in treatment for members with intellectual disabilities and/or Pervasive Developmental Disabilities, members must be at least eighteen (18) years old;

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AND

meet the eligibility requirement for persons with intellectual disabilities/pervasive developmental disorders as defined in 34-B M.R.S.A. Section 5001(3) and 6002. "Intellectual disability" means a condition of significantly sub-average intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period;

AND

be in jeopardy of not having a place to live, or not adequate supervision necessary to assure their health and safety. This determination will be made based on the results of a risk assessment and supported by the member's planning team;

AND

Require that supervision be available and on-site at all times;

AND

using the Department's Developmental Services Needs Inventory tool, have identified needs at the C, D, or E level in at least three of the categories. Providers may contact the Department to obtain this assessment tool.

4. Eligibility for Other Medical and Remedial Facilities

Some providers of Medical and Remedial Facilities treat members with a variety of medical needs not detailed above. To be reimbursed for services, providers must assure that members meet medical eligibility for at least one of the above Medical and Remedial Facility eligibility criteria detailed above including at a minimum the eligibility criteria for Appendix C or Appendix F above or eligibility as a public ward for Adult Protective Services as defined in 22 M.R.S.A Chapter 958-A.

97.03 DURATION OF CARE

Each MaineCare member is eligible for covered services that are medically necessary as determined by eligibility and continued eligibility requirements set forth in this Section. The Department reserves the right to request additional information to evaluate eligibility and continued eligibility for services.

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97.04 COVERED SERVICES – DIRECT SERVICE STAFF

A covered service is a service for which payment to a PNMI provider is permitted under the rules of this Section. Direct service staff is defined as staff who provide the services listed in this Section. MaineCare covers the following services when provided in an approved setting of a licensed Private Non-Medical Institution in accordance with Chapter III, Principles of Reimbursement for Private Non-Medical Institution Services, provided within the scope of licensure of the facility, and billed by that facility, and as identified in Section 97.08. Not all of the following services are included in the rate for every type of facility. Refer to the applicable Appendix in Chapter III for services that are included in the rate for each type of PNMI. The Chapter III Principles of Reimbursement for each type of Private Non-Medical Institution define which staff services are allowable. The service must be listed in the Principles of Reimbursement in order for the service to be reimbursable. Covered services may include, but are not limited to:

- 97.04-1 Physician services
- 97.04-2 Psychiatrist services
- 97.04-3 Psychologist services
- 97.04-4 Psychological examiner services
- 97.04-5 Licensed clinical social worker services
- 97.04-6 Licensed clinical professional counselor services
- 97.04-7 Licensed professional counselor services

- 97.04-8 Dentist services
- 97.04-9 Registered nurse services
- 97.04-10 Licensed practical nurse services
- 97.04-11 Psychiatric nurse services
- 97.04-12 Speech pathologist services
- 97.04-13 Licensed alcohol and drug counselor services
- 97.04-14 Licensed marriage and family therapist services
- 97.04-15 Occupational therapy services
- 97.04-16 Other qualified mental health staff services
- 97.04-17 Other qualified medical and remedial staff services
- 97.04-18 Other qualified alcohol and drug treatment staff services
- 97.04-19 Personal care services
- 97.04-20 Other qualified children's residential care facility services
- 97.04-21 Other qualified licensed treatment foster care provider services
- 97.04-22 Interpreter services
- 97.04-23 Nurse practitioner services
- 97.04-24 Physician assistant services
- 97.04-25 Clinical consultant services
- 97.04-26 Physical therapy services
- 97.04-27 Board certified behavior analyst services*
- 97.04-28 Board certified assistant behavior analyst services*
- 97.04-29 Registered behavior technician services*

***The Department shall seek CMS approval for these changes.**

97.05 LIMITATIONS

97.05-1 Collateral Contacts

Reimbursement shall be made for direct services, collateral contacts, and certain supportive services when there is not a direct encounter with the member, only as described in Chapter III, Principles of Reimbursement for PNMI, Section 2400, and when provided by qualified staff members.

97.05-2 Non-Duplication of Services

It is the responsibility of the PNMI provider to coordinate with other providers and services engaged in the member's care to address the full range of member needs. Other MaineCare covered services shall not duplicate PNMI services included in the facility's PNMI rate. Covered services, listed in the applicable Appendix, and/or in contracts with the Department, that are part of the PNMI rate are the responsibility of the PNMI to provide or arrange under contract as necessary with providers practicing within the scope of their licensure.

Services that are part of the PNMI rate may not be billed to MaineCare separately by other providers. Personal care services are included as part of the PNMI rate and shall be delivered by the PNMI provider and not by a MaineCare provider under any other Section of this Manual including personal support specialist (PSS) services under Section 96, Private Duty Nursing and Personal Care Services provider or other Section of MaineCare policy.

PNMI providers must coordinate their services with all other MaineCare services, including but not limited to case managers providing services outside the residential setting, in accordance with the provisions of Chapter II, Section 13, Targeted Case Management Services; Chapter II, Section 17, Community Supports Services; Chapter II, Section 91, Health Home Services; and Chapter II, Section 92, Behavioral Health Home Services of the *MaineCare Benefits Manual*.

97.05-3 Out-of-State Placement

Reimbursement shall not be made for Private Non-Medical Institution services provided out of state unless the services are medically necessary, and are not available within the State and prior authorization (as described in this Section and Chapter I, of the *MaineCare Benefits Manual*) has been granted.

97.05-4 State Social Security Insurance (S.S.I.) and Cost-Reimbursement

For members receiving State S.S.I. and cost-reimbursement benefits, in order for benefits to continue for a member who is temporarily admitted to a State institution, a hospital, or a nursing facility when the residential care facility

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provider has agreed to hold the bed, the provider must do the following:
a) Notify the Social Security Administration that the member has been admitted to an institution, and b) Notify the Social Security Administration that the bed is being held for the resident.

97.06 NON-COVERED SERVICES

Please refer to Chapter I of the *MaineCare Benefits Manual* for additional non-covered services, including services that are for vocational, academic, socialization or recreational purposes.

97.06-1 Room and Board and Other Non-Covered Services

All PNMI room and board costs, and other services such as telephone and television, are non-covered services under MaineCare.

97.06-2 Personal Care Services Provided by a Family Member

Personal care services provided by a family member are not a covered service and may not be billed by the family or by any other provider.

97.06-3 Non-Reimbursable Days

Bed-hold days are not reimbursable.

Days when a member is not present in the facility at 11:59 pm are not reimbursable and may not be billed by the provider.

Additionally, partial services delivered under this Section when a member is not in the facility at 11:59 pm are not reimbursable. Members receiving services in an emergency department are exempt from this provision when emergency treatment is sought at 8:00pm or later and the member returns to the facility the following day.

Aftercare Support Services, as described in 97.01-1, are not subject to this provision.

97.07 POLICIES AND PROCEDURES

97.07-1 Setting

Services shall be delivered in the Private Non-Medical Institution or other settings appropriate to individual service/treatment needs in accordance with an individual service/treatment plan and in the least restrictive manner and environment possible.

97.07 POLICIES AND PROCEDURES (cont.)

97.07-2 Qualified Staff

A Private Non-Medical Institution may be reimbursed for services provided by the following staff and as set forth in the Chapter III, Principles of Reimbursement for that type of institution:

A. Professional Staff

All professional staff must be conditionally, temporarily, or fully licensed, and/or certified and approved to practice as documented by written evidence from the appropriate governing body.

MaineCare may reimburse a PNMI for covered services as defined in Section 97.04 if they are provided by the following professional staff members: Clinician (as defined in 97.01-4), dentist, occupational therapist registered, licensed practical nurse, speech language pathologist, or board certified behavior analyst. All providers must hold appropriate licensure in the state or Province in which services are provided and must practice within the scope of these licensing guidelines. See Appendix D of Section 97, Chapter III, for PNMI covered services.

B. Other Qualified Mental Health Staff

Other staff may be considered qualified for purposes of this Section if they meet the following requirements:

1. They have education, training, or experience that qualifies them to perform certain specified mental health functions;
2. They receive certification from the Department, or its designee, that they are qualified to perform such functions and such verification is recorded in writing and kept in the files of the Department, or its designee; and
3. They perform such functions under the supervision of a licensed, certified, or registered health professional with the supervisory relationship having been described to and approved by the Department in accordance with its licensing and certification regulations.

C. Other Qualified Medical and Remedial Services Staff

Medical and remedial services and personal care services staff members may be considered qualified for purposes of this Section if they meet the following requirements:

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1. The services they provide are prescribed by a physician and are in accordance with the member's plan of care.
2. The facility has written documentation that each staff person has received orientation or is currently in orientation in keeping with the licensing regulations for medical and remedial services facilities cited in Section 97.01 15 (F) and is adequately performing medical and remedial services according to minimum standards set by the Office of MaineCare Services identified in the regulations cited above.
3. The medical and remedial services staff person is not a member of the member's family as defined in the Chapter III, Principles of Reimbursement for Medical and Remedial Service Facilities.

D. Other Qualified Alcohol and Drug Treatment Staff

Other qualified alcohol and drug treatment staff are staff members, other than professional staff defined above, who have appropriate education, training and experience in substance use treatment services, related disciplines as approved by the Office of Behavioral Health, or behavioral sciences; who work under a substance use treatment professional, consisting of at least one (1) hour per week for each twenty (20) hours of covered services rendered; and who are approved by the State Board of Alcohol and Drug Counseling as documented by written evidence on file with that office pursuant to Section 4.19 of the Regulations for Licensing/Certifying Substance Use Treatment Facilities in the State of

Maine. A Certified Alcohol and Drug Counselor is considered to be an other qualified substance use staff member.

E. Personal Care Service Staff

Personal care service staff may be considered qualified for purposes of this Section if they meet the following requirements:

1. The personal care services provided by all PNMI's are prescribed by a physician upon or within thirty (30) days of admission, are in accordance with the member's plan of care, are supervised by a registered nurse at least every ninety (90) days, and are not provided by a member of the member's family as described in Section 97.01-5 or the pertinent Appendix of Chapter III, Principles of Reimbursement.
2. The following facilities shall have written documentation that each staff person has received orientation in keeping with the licensing

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regulations for: a) community residences for people with mental illness, cited in Section 97.01-15(E) or, b) as outlined in the residential services agreement required by the Department of Health and Human Services licensing requirements cited in Section 97.01-15 (D); or c) in accordance with licensing regulations for residential substance use treatment PNMI as cited in Section 97.01-15(B).

Substance use treatment PNMI shall maintain documentation that each staff member providing such services has received forty (40) hours of orientation and training in personal care procedures appropriate to residents.

Areas of training must include an introduction to substance use disorders, assistance in self-administration of medication, infection control, bowel and bladder care, nutrition, methods of moving patients, and health-oriented record keeping.

Personal care service staff shall adequately perform personal care services according to minimum standards set by the Department when providing services in community residences for people with mental illness.

F. Provider Requirements for Appendix D MH and ID/DD CRCFs

All MH and ID/DD CRCF providers operating under Appendix D of these rules must meet the following requirements:

Meet Qualified Residential Treatment Program (Q RTP) standards as defined in Section 50741 of the federal Family First Prevention Services Act (H.R. 1892):

- a. Has a trauma-informed treatment model designed to address the needs, and clinical needs, as appropriate, of children with serious emotional or behavioral disorders or disturbances; can implement the necessary treatment identified in the child's assessment;
- b. Has a Clinician who can provide care, who is on-site consistent with the treatment model, and available twenty-four (24) hours and seven (7) days a week;
- c. Has a nurse available to the provider, either as an employee or contracted non-employee, twenty-four (24)

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hours per day, seven (7) days per week. The nurse may provide in-person, telehealth, and/or telephonic support outside of normal business hours as needed. The nurse must be either a psychiatric mental health nurse practitioner (APRN-PMH-NP), or a registered nurse (RN) with experience in the treatment of children with serious behavioral health conditions or requisite training to treat children with serious behavioral health conditions;

- d. Facilitates family participation in child's treatment program, if in child's best interest;
- e. Facilitates family outreach, documents how this outreach is made, and maintains contact information for any known biological family and fictive kin of the child;
- f. Documents how the child's family is integrated into the child's treatment, including post-discharge, and how sibling connections are maintained;
- g. Provides discharge planning and family-based Aftercare Support Services for at least six (6) months post-discharge*; and
- h. The provider is licensed and nationally accredited by approved entities as follows:
 - 1. Obtains and maintains licensure as a Children's Residential Care Facility with the State of Maine Division of Licensing and Regulatory Services pursuant to 10-144 C.M.R. Chapter 36, Children's Residential Care Facilities Licensing Rule; and
 - 2. Obtains and maintains accreditation from one of the entities outlined below:
 - a. The Commission on Accreditation of Rehabilitation Facilities (CARF);
 - b. Council on Accreditation (COA);
 - c. The Joint Commission (formerly JCAHO); OR
 - d. Another accrediting body as approved by the Department.

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- e. The provider must achieve accreditation within twelve (12) months of the effective date of this rule or being licensed and otherwise ready to be a MaineCare provider. The provider shall:
 - i. Provide written documentation that the accreditation process has been initiated;
 - ii. Include a plan for full accreditation within twelve (12) months; and
 - iii. Submit written updates every three (3) months documenting progress toward full accreditation. If the provider fails to obtain full accreditation within twelve (12) months, the Department may take appropriate action up to and including, termination of provider enrollment rendering future services not reimbursable.

***The Department shall seek CMS approval for these services.**

G. Provider Requirements for all Appendix D CRCFs and Appendix B Adolescent Residential Rehabilitation Services

All CRCF providers operating under Appendix D and Adolescent Residential Rehabilitation Services operating under Appendix B of these rules must meet the following requirements:

1. Obtain and maintain an approved application from OCFS, or designee, in addition to the MBM Ch I, Section 1 enrollment requirements.
2. Participate in quality assurance reviews conducted by OCFS to include on-site and/or document quality reviews which may result in quality improvement recommendations.
3. Demonstrate utilization of the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) System of Care Principles to include:
 - a. Documentation of policies and procedures that incorporate System of Care Principles; and

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- b. Documentation of System of Care Principles training for all staff to be completed within ninety (90) days of hire, and as requested by the Department.
- 4. Demonstrate delivery of Trauma-Informed Care to include:
 - a. Completion of a Trauma-Informed Agency Assessment annually, or as requested by the Department, and make the results of this assessment available to the Department which may result in quality improvement recommendations.
 - b. Documentation of policies and procedures that incorporate Trauma Informed Care; and
 - c. Documentation of Trauma Informed Care training for all staff to be completed within ninety (90) days of hire, and as requested by the Department.
- 5. Adhere to Reportable Event standards pursuant to 10-144 C.M.R. Chapter 36, Children's Residential Care Facilities Licensing Rule; mandated reporting standards pursuant to Title 22 M.R.S. §4011 (A); OADS Reportable Event standards pursuant to 14-197 C.M.R Ch 12; and as otherwise required by the Department.
- 6. Adhere to Background Check Requirements pursuant to 10-144 C.M.R. Chapter 36, Children's Residential Care Facilities Licensing Rule and set forth in 22 M.R.S. § 8110 and 42 U.S.C. § 671(20). Within ninety (90) days of the effective date of this rule, all staff members must have comprehensive background checks completed. Costs associated with requirements for background checks and fingerprinting are the provider's responsibility.
- 7. Advise the member and the member's parent(s) or legal guardian(s) of the member's rights pursuant to the *Rights of Recipients of Mental Health Services Who Are Children in Need of Treatment*, 14-172 C.M.R. ch.1, and provide a written copy of these rights in a language that the member and their parent(s) or legal guardian(s) understand. For members who are 18 years of age or older, or who are emancipated minors, the facility must also advise the member of their rights pursuant to the *Rights of Recipients of Mental Health Services*, 14-193 C.M.R. ch.1, and provide a written copy of these rights to the member. The member (if over the age of eighteen (18) or emancipated) or the member's parent or legal guardian (if a minor) must sign acknowledgement that the member has been

97.07 POLICIES AND PROCEDURES (cont.)

advised of their rights and received a written copy of their rights.
This documentation will be maintained in the member's file.

H. Other Qualified Children's Residential Care Facility Staff for Appendix D CRCFs

The following staff may work for providers as described under Appendix D of this section, except for Child and Adolescent Therapeutic Foster Care, and must meet the following criteria:

1. Behavioral Health Professional (BHP) Children's Residential Care Facility Staff

A Behavioral Health Professional is a staff requirement to provide services in CRCFs. To qualify for the BHP certification, individuals must meet the minimum following criteria:

- a. Be 18 years of age or older;
- b. Have a high school diploma or equivalent;
- c. Obtain BHP certification; and
- d. Must not be annotated on the Certified Nursing Assistant and Direct Care Worker Registry Rule (10-144 C.M.R. ch. 128).

All prospective BHP staff meeting the educational and other criteria outlined above, must begin receiving BHP training within thirty (30) days of the date of hire and complete the BHP training and obtain certification within six (6) months of the date of hire.

Staff who are employed at the time this rule goes into effect as direct care professionals and do not have BHP certification are considered qualified to provide this service and must complete BHP training and obtain certification within twelve (12) months of hire or of the effective date of this rule. Approvals must be maintained in the agency's personnel file and the length of provisional status documented in the employee's file.

Staff who have not completed certification requirements in full within six (6) months of the date of hire, or within twelve (12) months for staff who are employed at the time this rule goes into effect, are not eligible to perform reimbursable services with any provider until certification is complete.

Providers are required to maintain documentation of staff trainings and certifications within the employee personnel files.

97.07 POLICIES AND PROCEDURES (cont.)

2. Registered Behavior Technician (RBT) Children's Residential Care Facility Staff

A Registered Behavior Technician (RBT) is a staff requirement for the provision of ID/DD CRCF services (97.08-2 (A)(1)). To qualify as a Registered Behavior Technician, individuals must meet the minimum following criteria:

- a. Meet all criteria outlined in 97.07-2 (H)(1); and
- b. Obtain RBT certification through the Behavior Analyst Certification Board.

All RBT staff meeting the educational and other criteria outlined above, must complete the RBT training and obtain certification within six (6) months of the date of hire.

Staff who are employed at the time this rule goes into effect as direct care professionals and do not have RBT certification are considered qualified to provide this service and must complete RBT training and obtain certification within twelve (12) months of hire or of the effective date of this rule. Approvals must be maintained in the agency's personnel file and the length of provisional status documented in the employee's file.

Staff who have not completed certification requirements in full within six (6) months of the date of hire, or within twelve (12) months for staff who are employed at the time this rule goes into effect, are not eligible to perform reimbursable services with any provider until certification is complete.

Providers are required to maintain documentation of staff trainings and certifications within the employee personnel files.

3. Family Transition Specialist (FTS) Children's Residential Care Facility Staff

A Family Transition Specialist is a staff requirement for the provision of Aftercare Support Services (97.01-1). To qualify as a Family Transition Specialist, individuals must meet the minimum following criteria:

- a. Meet all criteria outlined in 97.07-2 (H)(1); and
- b. Hold a bachelor's degree in social work or a related human services field from an accredited university; or hold a bachelor's

97.07 POLICIES AND PROCEDURES (cont.)

degree in an unrelated field with at least one (1) year of professional experience in the human services field.

4. Supervision of Other Qualified Children's Residential Care Facility Staff

- a. All Other Qualified CRCF staff employed full-time must be supervised a minimum of three (3) hours per month to include:
- one (1) hour of individual supervision, and
 - one (1) hour of clinical supervision conducted by a Clinician as defined in 97.01-4.

Direct care staff employed part-time must receive a prorated amount of supervision, with a minimum requirement of one (1) hour per month.

- b. Behavioral Health Professionals and Registered Behavior Technicians employed by Intellectual Disability/Developmental Disability Children's CRCFs must receive a minimum of one (1) hour per month of supervision from a Licensed Psychologist, Board Certified Behavior Analyst (BCBA) or equivalent as determined by the Department. This specialized supervision is required for staff providing Applied Behavior Analysis services and may count toward the three (3) hour per month total supervision requirement.
- c. Family Transition Specialists must receive clinical supervision that is directly related to youth transitioning and receiving Aftercare Support Services.

I. Other Qualified Licensed Treatment Foster Care Providers

Other qualified licensed treatment foster care providers are licensed treatment foster care homes/parents who hold a contract to provide treatment foster care services to State agency clients.

J. Interpreter Services

See Chapter I for provider rules regarding Interpreter Services.

K. Clinical Consultant Services

Clinical consultant services must be provided by licensed or certified professionals as described in Chapter II, Section 97.07-2, of these rules, and working within all State and Federal regulations specific to the services provided.

97.07 POLICIES AND PROCEDURES (cont.)

For those facilities covered under Chapter II, Appendix B, substance use facilities, clinical consultants may include substance use services including Medication Assisted Treatment (MAT) services.

97.07-3 Assessment and Individual Service Plan/Individual Treatment Plan

Qualified staff must provide reimbursable services following a written individual service plan/individual treatment plan. The service/treatment plan must be developed and reviewed in accordance with these rules for either substance use treatment facilities, children's residential care facilities, community residences for persons with mental illness, medical and remedial services facilities, or non-case mixed medical and remedial facilities. PNMI staff must assess members for unmet physical and mental health needs and complement the individual service/treatment plan with appropriate referrals for health care.

ID/DD and MH CRCF providers, under Appendix D of this Section, must additionally meet the following requirements:

A. CRCF Assessment

1. The provider will conduct a comprehensive assessment within thirty (30) days of admission to the facility. The assessment must be conducted by a Clinician as defined in 97.01-4.
2. The comprehensive assessment must include the reason for referral and identify strengths and needs in the following domains: Family History, Child Welfare Involvement/Permanency Needs, Social, Emotional, Developmental, Medical/Dental (including a current list of prescribed medications), Substance Use (including screening for Substance Use Disorders), Legal, Housing, Financial, Educational/Vocational, Recreation, Transition Needs (for members sixteen (16) years old or more), Crisis/Safety Plan, Trauma History (including screening for trauma) and cultural strengths, supports and needs, including any language barriers or need for interpreters and/or cultural broker.
3. The assessment must summarize the member's strengths, needs, natural supports, and overall treatment goals, including the family's strengths and potential barriers to family involvement in treatment. Recommended service intensity and modalities for treatment will also be included. The assessment must include a diagnosis using the most recent *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM). The assessment must be signed, credentialed, and dated by the Clinician conducting the assessment.

97.07 POLICIES AND PROCEDURES (cont.)

4. Providers delivering services under the Intellectual Disabilities/Developmental Disabilities CRCF model must complete a Functional Behavior Assessment (FBA) as part of the comprehensive assessment. The FBA will be conducted by a licensed Psychologist or BCBA. The FBA will be updated every thirty (30) days in conjunction with the ITP or more frequently as indicated by the member's needs. The FBA must be provided to the youth and family and/or caregiver in language that is easily understood.

B. CRCF Individual Treatment Plan (ITP)

All members will have an active ITP, which must:

1. Be developed and implemented within thirty (30) days of admission and provided to the youth and family and/or caregiver in language that is easily understood;
2. Be developed by an interdisciplinary team, minimally to include the Clinician, the member, and their family/legal guardian; as well as the CRCF supervisor, the facility nurse (RN or APRN-PHN-NP), the BCBA, direct care staff, PCP, siblings, natural supports, etc., as applicable;
3. Reflect the needs and strengths identified in the Level of Care/Service Intensity tool completed prior to intake, and the assessment;
4. Include a plan for discharge and document progress toward the earliest possible discharge;
5. Include short and long-term goals with target dates that are observable and measurable;
6. Describe the specific type of treatment modalities to be used and the clinical rationale for each;
7. Include individual and family therapy goals and objectives;
8. Describe the frequency, intensity and duration of treatment;
9. Specify the staff roles and responsibilities in treatment interventions, member role and responsibilities, and family roles and responsibilities; and
10. Include a discharge plan which must:

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- a. Identify individualized discharge criteria that are related to the goals and objectives described in the ITP, as well as noting the member's progress toward meeting discharge criteria;
- b. Identify the individuals responsible for implementing the plan, including staff who will assist the member in making referrals for other resources;
- c. Identify natural and other supports necessary for the member and family to maintain the safety and well-being of the member, and to sustain progress made during treatment;
- d. Identify any service recommendations, reasons for recommending that service, and the plan for referring the member to the service; and
- e. Address behavior planning, including interventions and resources necessary for the member and their family/caregiver to manage crises or treatment needs following discharge.

97.07-4 Member's Record

The provider must keep a record for each member that includes, as applicable, but is not necessarily limited to:

- A. The member's name, address, and birthdate;
- B. The member's medical and social history, as appropriate;
- C. The member's diagnosis. The attending physician or psychiatrist, if applicable;
- D. Long and short range medical and other goals, as appropriate;
- E. A description of any tests ordered by the PNMI and performed and results;
- F. A description of treatment, counseling, or follow-up care;
- G. Notation of any medications and/or supplies dispensed or prescribed;
- H. Plans for coordinating the services with other agencies, if applicable;
- I. The discharge plan of the member;
- J. Written and signed progress notes as appropriate and frequency for each type of facility or PNMI, weekly or daily depending upon the type of

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facility, which shall identify the services and/or treatment provided and progress toward achievement of goals.

- K. Providers operating under Appendix D of this Section must additionally meet the following requirements for CRCF Progress Notes:
1. Providers must maintain written progress notes for each service discipline provided by the CRCF, in chronological order. There must be one (1) progress note per shift and all medication/nursing/therapy services must be documented individually.
 2. All entries in the progress note must include the service provided, the provider's signature and credentials, the date on which the service was provided, the duration of the service, and progress the member is making toward attaining goals or outcomes identified in the Individualized Treatment Plan.

97.07-5 Program Integrity

See Program Integrity (formerly Surveillance and Utilization Review) in the MBM Chapter I.

97.07-6 Review of the Individual Service Plan/Individual Treatment Plan

A review of the individual service/treatment plan shall be conducted by the appropriate case review team and/or professional of the following facilities in accordance with the following:

- A. for substance use treatment facilities, the rules and regulations cited in Section 97.01-15(B);
- B. for children's residential care facilities, the rules and regulations cited in Section 97.01-15(D); and
- C. for community residences for persons with mental illness, the rules and regulations cited in Section 97.01-15(E);
- D. for community residences for persons with mental illness, reviews must be made at least every ninety (90) days;
- E. for medical and remedial services facilities, the regulations cited in Section 97.01-15(C); and

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- F. for non-case mixed medical and remedial facilities, the rules cited in Section 97.01-15(F) and the Chapter III, Principles of Reimbursement for Non-Case Mixed Medical and Remedial Facilities.

97.07-7 Discharge Summary

A discharge summary shall summarize the entire case in relationship to the plan of care.

For ID/DD and MH Children's Residential Care Facility services under Appendix D, the discharge summary must be completed within thirty (30) days of discharge and include the following:

- A. Date of discharge, reason for discharge and the name, telephone number, address and relationship of the person(s) or provider to whom the member was discharged;
- B. A summary of the services provided during the member's treatment, including the member's progress during treatment and any unmet needs;
- C. The member's diagnosis at discharge, using the most current edition of the DSM; and
- D. Disposition of the member's care, including services recommended and the plan for follow-up services, including identification of who is responsible for continued services and provisions for Aftercare Support Services as described in section 97.08-2 (G).

97.07-8 Time Studies

- A. The Department requires time studies for educational staff performing duties as described in Section 97.06 to determine if a percentage of the time can be applied to direct service staff and is an allowable cost under Chapter III, Principles of Reimbursement for Private Non-Medical Institutions, Section 2400. The percentage of time determined in the time study that is applicable to academic services listed in MBM Chapter I, Section 1.06-4, Non-Covered and Non-Reimbursable Services will not be allowable time (and the costs related to that time) under Chapter III, Section 2400.
- B. The Department requires time studies of direct time for staff who perform both covered direct services and other non-covered services for facilities covered under Appendices B, D, and E. The percentage of time

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determined from the time study spent in duties as described in Section 97.04 is an allowable cost under Chapter III, Principles of Reimbursement for Private Non-Medical Institutions, Section 2400.

- C. Facilities must complete time studies in accordance with procedures prescribed by the Office of MaineCare Services.

97.07-9 Continuing Stay Requirements

Members must continue to meet the eligibility criteria set forth in each Section above for provider reimbursement in the PNMI setting.

97.07-10 Termination

For members receiving Appendix E services under this Section, providers must:

- A. Obtain written approval from the Director of the Office of Behavioral Health (OBH) or designee prior to terminating services to that member;
- B. If approved by OBH, issue a thirty (30) day advanced written termination notice to the member prior to termination of the member's services. In cases where the member poses a threat of imminent harm to persons employed or served by the provider, the Director of OBH may approve a shorter notification for termination of services; and
- C. Assist the member in obtaining clinically necessary services from another provider prior to discharge or termination.

97.07-11 Referrals

Providers must acknowledge receipt of Department referrals within three (3) business days for members deemed eligible for Appendix E services. Providers must accept or request permission to decline referrals in accordance with a Department-defined process within five (5) business days of receipt of the referral. Only in cases where providers have received written approval from OBH may a referral be declined; otherwise, providers must admit members within thirty (30) days of receipt of the referral.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES

Requirements identified in this Section shall be the responsibility of direct care staff. Direct care services include supervisory and training activities necessary to accomplish the provisions described in this Section. It also includes personal supervision or being aware of members' general whereabouts, observing or monitoring members to ensure

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

their health and safety, assisting with or reminding members to carry out activities of daily living, and assisting members in adjusting to the facility and community.

97.08-1 Substance Use Treatment PNMI's – Medical and Clinical Requirements

A. Medical and Clinical Responsibility

Clinical responsibility for implementation of each member's overall specific treatment plan shall rest with a treatment team, which shall be chosen from the qualified professional staff as defined in Section 2400 of the pertinent Chapter III, Principles of Reimbursement.

All services must be provided pursuant to a written service plan based upon an individual assessment made in accordance with the Regulations for Licensing/Certifying Substance Use Treatment Programs in the State of Maine.

Service plans must be reviewed and signed by a Clinician as defined in Chapter II, Section 97.01-4. Such qualified professional staff shall be responsible for the provision of direct services to members, and for direct supervision of all other staff in the implementation of the service plan through the various elements of the comprehensive treatment described in this Section. The qualified professional staff shall ensure that a full range of formal treatment services is provided to each member in conjunction with the structured set of activities routinely provided by the PNMI and in accordance with the individual member's needs. The range of formal treatment services provided to members by the PNMI shall aid the member, through medically supervised withdrawal services, type I residential rehabilitation, type II residential rehabilitation, halfway house services, extended care, adolescent residential rehabilitation, or personal care substance use services (shelter based), toward the primary goal of recovery for members with substance use disorders.

PNMI staff shall assess members for unmet mental health needs and complement the substance use plan of care with appropriate referrals for mental health care.

PNMI staff must coordinate care with the member's treatment team and facilitate access to any identified services and supports, including but not limited to case managers providing services outside the residential setting, in accordance with the provisions of Chapter II, Section 13, Targeted Case Management Services; Chapter II, Section 17, Community Supports Services; Chapter II, Section 91, Health Home Services; and Chapter II, Section 92, Behavioral Health Home Services of the *MaineCare Benefits Manual*.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

B. Personal Care Services

PNMIs approved and funded by Office of Behavioral Health in licensed facilities must also provide necessary personal care services for the promotion of ongoing treatment and recovery. MaineCare does not cover personal care services provided by a family member.

Personal care services shall be prescribed by a physician, provided by qualified staff, and will occur in the substance use treatment PNMI where the member receiving services resides.

Personal care services shall consist of, but are not limited to, the following

- Assistance or supervision of activities of daily living that include bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks essential to the activities of daily living and to the maintenance of the member's health and safety within the substance use treatment PNMI;
- Supervision of or assistance with administration of physician-ordered medication;
- Personal supervision or being aware of the member's general whereabouts, observing or monitoring the member while on the premises to ensure their health and safety, reminding the member to carry out activities of daily living, and assisting the member to carry out activities of daily living, and assisting the member in adjusting to the group living facility;
- Arranging transportation and making phone calls for medical or treatment appointments as recommended by medical providers, or as indicated in the member's plan of care;
- Observing and monitoring member's behavior and reporting changes in the member's normal appearance, behavior, or state of health to medical providers or supervisory personnel as appropriate;
- Arranging or providing motivational, diversionary, and behavioral activities that focus on social interaction to reduce isolation or withdrawal and to enhance communication and social skills necessary for ongoing treatment and recovery, as described in the member's plan of care;

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

- Monitoring and supervising member's participation in the treatment; and
- Psychosocial treatment including assisting members to adjust to the substance use treatment PNMI, to live as independently as possible, to cope with personal problems during periods of stress, to accept and adjust to their personal life situations, to accept and cope with their substance use disorders and to decrease maladaptive behaviors leading to possible relapse into active addiction, in addition to providing services and a supportive environment which promotes feelings of safety and freedom from danger, fear or anxiety.

C. Medically Supervised Withdrawal Services

MaineCare limits non medically supervised withdrawal services to seven (7) days for each admission episode, with no limit on the number of admissions or covered days on an annual basis. The facility may provide medically supervised withdrawal services for a longer period if medical necessity is substantiated and ordered by the medical director and documented in the member's clinical file by the facility's designated medical staff.

Medically supervised withdrawal services provide immediate diagnosis and care to members having acute physical problems related to substance use. Providers of medically supervised withdrawal services shall make and maintain arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI, including but not limited to Medication Assisted Treatment (MAT) services .

Each member shall receive a complete physical examination by a physician within forty-eight (48) hours of admission and the results shall be entered in the member's record. Admissions resulting from a direct physician referral by telephone may be sufficient to meet this requirement so long as the orders are taken by an RN or an LPN who has been trained to take telephone orders. The referring physician shall sign these orders within forty-eight (48) hours.

PNMIs shall provide medical evaluation and diagnosis upon intake. Designated areas suitable (1) for the provision of general medical services, and (2) to control and administer drugs prescribed by the PNMI's legally qualified staff, shall be maintained by the PNMI so as to assure the appropriate treatment of physical illness and maintenance of good general health among members. The member shall receive

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

continuing medical supervision under the direction of a physician while in the PNMI that shall be documented in the member's case record. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals and physical examinations.

The PNMI's qualified staff shall teach skills and habits conducive to lifestyle choices which reduce risk and foster successful long-term recovery. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall maintain a medical staffing pattern, which enables it to meet the physical care requirements delineated above. The PNMI shall provide for twenty-four (24) hour, on-premises medical coverage by a registered nurse or licensed practical nurse who is experienced in the disease and treatment of substance use disorders. Physician back up and on-call staff shall be provided to deal with medical emergencies.

D. Residential Rehabilitation Type I

MaineCare limits residential rehabilitation type I to forty-five (45) days for any single admission, with a limit of two (2) admissions and forty-five (45) covered days on an annual basis per member. These limits allow some clinical flexibility should additional treatment be required, or should a member drop out very early in treatment and are admitted at a later date.

Any continuous stay in excess of forty-five (45) days requires documented need in the member's treatment plan.

Residential rehabilitation shall provide scheduled therapeutic treatment consisting of diagnostic and counseling services conducive to lifestyle choices which reduce risk and foster successful long-term recovery.

Each member shall receive a complete physical examination by a physician within seventy-two (72) hours of admission and the results shall be entered in the member's record. Admissions resulting from a direct physician referral by telephone may be sufficient to meet this requirement so long as the orders are taken by an RN or an LPN who has been trained to take telephone orders. The referring physician shall sign these orders within forty-eight (48) hours.

PNMIs shall provide medical evaluation upon intake and laboratory examinations as deemed appropriate by the physician as soon as

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

practicable after admission. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals, and physical examinations. Arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI, including but not limited to MAT services, shall be made and maintained by the PNMI.

The PNMI's qualified staff shall teach skills and habits conducive to lifestyle choices which reduce risk and foster successful long-term recovery. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling at a minimum of ten (10) hours per week.

The PNMI shall maintain a medical staffing pattern, which enables it to meet the physical care requirements delineated above. The PNMI shall provide for twenty-four (24)-hour staff coverage. Physician back-up and on-call staff shall be provided to deal with medical emergencies. The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section. For the purposes of this Section, physician consultant services are not considered subcontracting.

E. Adolescent Residential Rehabilitation Services

Adolescent residential rehabilitation PNMIs provide the opportunity for recovery through modalities, which emphasize personal growth through family and group support and interaction. The PNMI's qualified staff shall teach attitudes, skills, and habits, conducive to facilitating the member's transition back to the family and community. Adolescent residential rehabilitation PNMIs are designed to last at least three (3) months and are limited to twelve (12) months per single admission.

MaineCare does not cover in-house, accredited, individualized schooling, weekly vocational exploration groups, and structured recreational activities.

Services must include but are not limited to:

- Medical evaluation;
- Physical examination within seventy-two (72) hours following admission or no more than thirty (30) days prior to admission, and laboratory examinations as appropriate and as soon as practicable after the member's admission;

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

- Individual and group counseling at a minimum of ten (10) hours per week for each member;
- Arrangements for needed health care services; and
- Planning for and referral to further treatment.

The PNMI shall document that all persons providing services are legally qualified through licensure, certification, and/or registration as required to provide the service. PNMI shall have qualified (as described in Section 2400 of these principles) staff coverage twenty-four (24) hours a day, including weekend coverage and shall include weekly clinical supervision to the staff to ensure the well-being of the members and to provide for the growth and development of the staff.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section. For the purposes of this Section, physician consultant services are not considered subcontracting.

F. Halfway House Services

MaineCare limits halfway house services to one hundred eighty (180) covered days on an annual basis per member with no limit on the number of admissions. Any combined stay in excess of one hundred eighty (180) days requires documented need in the member's service plan.

A halfway house shall provide scheduled therapeutic and rehabilitative treatment consisting of transitional services conducive to lifestyle choices which reduce risk and foster successful long-term recovery in an unsupervised community living situation.

Counseling staff of the PNMI shall perform an assessment of the member's medical and social/psychological needs, as required by the Office of Behavioral Health, within five (5) days of admission unless the member can show evidence of such examination within the last thirty (30) days. Such assessment may be completed prior to admission by the substance use treatment facility referring the member. This assessment may additionally include, but not be limited to an examination for contagious or infectious disease, determination of the status of chronic physical disease and examination of nutritional deficiencies.

Arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI, including but not limited to MAT services, shall be made and maintained by the PNMI.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to facilitating the member's transition back to the community. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall have a written agreement with an ambulance service to assure twenty-four (24)-hour access to transportation to emergency

medical care facilities for members requiring such transport. Physician back-up and on-call staff shall be provided to deal with medical emergencies.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section, with the exception of physician consultant services.

G. Extended Care Services

MaineCare limits extended care services to two hundred seventy (270) covered days on an annual basis per member with no limit on the number of admissions. Any combined stays in excess of two hundred seventy (270) days requires documented need in the member's treatment plan.

Extended care services shall provide a scheduled therapeutic plan consisting of treatment services conducive to lifestyle choices which reduce risk and foster successful long-term recovery within a supportive environment.

Each member shall receive a complete physical examination by a physician within seventy-two (72) hours of admission and the results shall be entered in the member's record. Physical examinations performed more than thirty (30) days before admission are not acceptable. If the member's admission was based on the results of a physical examination performed thirty (30) or fewer days before admission, the PNMI's physician must approve the prior examination or re-examine the member within forty-eight (48) hours after admission. PNMI's shall provide medical evaluation upon intake and laboratory examinations as deemed appropriate by the physician as soon as practicable after admission. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals, and physical examinations. The PNMI is responsible for referring the member to external clinicians and facilities for specialized services beyond the capability of the PNMI, including but not limited to MAT services.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to facilitating the member's transition back to the community. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall have a written agreement with an ambulance service to assure twenty-four (24)-hour access to transportation to emergency medical care facilities for members requiring such transport. Physician back-up and on-call staff shall be provided to deal with medical emergencies.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section, with the exception of physician consultant services.

H. Residential Rehabilitation Type II

Residential Rehabilitation Type II will provide a structured therapeutic environment for members who are on a waiting list for treatment, or who have either completed medically supervised withdrawal services, or are otherwise not in need of medically supervised withdrawal services. The primary objectives of Residential Rehabilitation Type II are to stabilize members with substance use disorders, to provide continuity of treatment, to enable the member to develop a supportive environment conducive to lifestyle choices which reduce risk and foster successful long-term recovery, and to develop linkages with community services.

The term of residency shall not exceed sixty (60) days. The PNMI shall provide a daily structured sequence of individual and/or group counseling for the treatment of substance use provided by qualified staff members (listed in Section 2400 of the pertinent Chapter III, Principles). MaineCare does not cover other educational and vocational counseling required by the Office of Behavioral Health Regulations for Extended Care Shelters.

Services provided will depend upon the therapeutic needs of individual members and must include but are not limited to:

- Evaluation of the member's medical and psychosocial needs;
- A medical examination by a physician within five (5) days of admission unless the member can show evidence of such examination within the last thirty (30) days;
- Opportunities for learning basic living skills, such as personal hygiene skills, knowledge of proper diet and meal preparation,

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97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

constructive use of leisure time, money management and interpersonal relationship skills, all of which are considered non-covered services by MaineCare;

- Clinical services, including individual and group counseling; and
- Opportunity for family involvement.

The PNMI shall have twenty-four (24)-hour coverage by on-site trained staff (as required by Office of Behavioral Health) and include weekend coverage.

Each PNMI shall provide at least one (1) hour per week of professional consultation to the clinical staff to ensure the wellbeing of the members and to provide for the growth and development of the staff. This consultation may be either on a group or individual basis.

The PNMI shall assure the availability of a transportation support system twenty-four (24)-hours a day and shall maintain a written agreement for the provision of transportation between the facility and emergency care facilities.

97.08-2 Children's Residential Care Facilities (CRCF)*

***The Department shall seek CMS approval for these services.**

CRCF services are designed to provide comprehensive, trauma-informed, child-centered, and family-focused behavioral health treatment to children and adolescents. Services are provided in a supervised therapeutic environment in which skills and principles learned in clinical treatment may be reinforced and practiced with the goal of safely transitioning the member back into the community within a family setting. CRCF services are short-term and intensive in nature using a trauma-informed and culturally responsive treatment model, while also actively engaging the member's family or caregiver in treatment, as clinically indicated. CRCF providers may utilize evidence-based practices as clinically indicated. Services must be provided in the least restrictive setting, with the goal of placement as close to the child's home as possible which requires families and/or caregivers to remain actively involved in the child's treatment.

A. Four (4) models of service for children's CRCFs:

1. Intellectual Disabilities/Developmental Disabilities CRCFs,
2. Mental Health CRCFs,
3. Crisis Stabilization CRCFs, and
4. Therapeutic Foster Care.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

1. Children's Intellectual Disabilities/Developmental Disabilities (ID/DD CRCF) Services is a model of service delivery that provides short-term clinical treatment through a twenty-four (24) hour per day, seven (7) per week safe and therapeutic environment to address moderate to severe aggression, severe disruptive behaviors, and/or severe emotional dysregulation as determined by clinical assessment and level of care determination as outlined in these rules.

This model of service utilizes evidence-based behavioral interventions designed to improve pro-social behaviors and developmentally appropriate skills and reduce challenging behaviors to a measurable degree using Applied Behavior Analysis (ABA) as allowed in these rules as well as other clinically appropriate evidence-based techniques, models, or modalities, delivered with fidelity, that would benefit the member's needs as identified in the assessment.

Services are focused on improving the member's functioning and skills in emotional regulation, social communication, and problem-solving, while reducing disruptive and/or unsafe behaviors that may risk harm to the member or others. Services will also actively engage the member's family and/or caregivers in the member's treatment and treatment planning to build skills to support the member's ability to safely function at home and in the community, including specific training sessions in the member's individualized positive behavior support plan.

Discharge planning will take place from date of admission and the member will be served in the least restrictive environment possible. Providers in this model must adhere to the Rights and Basic Protections of a Person with an Intellectual Disability or Autism (34-B M.R.S. §5605).

2. Children's Mental Health CRCF (MH-CRCF) is a model of service delivery for members with serious emotional disturbance (SED) who require on-site clinical treatment and a safe, supportive therapeutic environment to gain skills and stabilize behavior that will result in a safe transition back into their community.

The purpose of MH-CRCFs is to provide clinically appropriate, trauma-responsive, comprehensive, child-focused, and family-centered services to treat the member's mental health condition(s) and return the child to their family, home, and community as soon as possible.

MH-CRCFs provide active behavioral health treatment and skills development as guided by a treatment plan developed in collaboration with the member and their family/caregivers in a safe, structured, and

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

therapeutically supervised living environment twenty-four (24) hours per day, seven (7) days per week.

Services will actively engage the member's family and/or caregivers in the member's treatment to build skills which support the member's ability to safely function at home and in the community. Discharge planning will take place from date of admission and the member will be served in the least restrictive environment possible.

3. Children's Crisis Stabilization (CS-CRCF) is a model of service delivery that provides individualized therapeutic interventions in a secure setting during a psychiatric emergency to address mental health and/or co-occurring mental health and substance use conditions. A psychiatric emergency occurs when the member is at imminent risk of serious harm to self or others, and even with intensive community intervention there is significant potential that the member will be hospitalized.

Services are short-term, time-limited, focused on crisis stabilization and establishing a safe plan for the member to return to their community while accessing ongoing services as needed.

Components of crisis stabilization include assessment, monitoring behavior, assessing the member's response to therapeutic interventions, planning for, and implementing crisis and post stabilization activities, and supervising the member to ensure personal safety.

While crisis services do not require Prior Authorization, providers must contact the Department within forty-eight (48) hours to get approval of continued reimbursement for this service using the prior approval process detailed in this Section.

4. Child and Adolescent Therapeutic Foster Care is a family-based model of service delivery which provides treatment to children with moderate to severe behavioral health and developmental needs. Treatment is delivered through services integrated with key interventions and supports provided by therapeutic foster parents who are trained, supervised, and supported by qualified therapeutic foster care provider staff. The delivery of treatment is a shared responsibility between the independently licensed clinical staff and the therapeutic foster parents. Therapeutic foster care is designed to allow children receiving treatment to reside in a family-like setting as opposed to institutional settings, while receiving treatment.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

B. Temporary High Intensity Services (THIS)

THIS are available to eligible members receiving CRCF services, except Therapeutic Foster Care, as described in 97.02-5.

The purpose of this temporary service is to stabilize a child who experiences an escalation in aggression, self-injurious behavior, and/or suicidal ideation that has not improved using the typical service intensity and modalities of the CRCF. The behaviors, if left untreated, are likely to result in the member needing a higher level of care. THIS may include additional staff, specialized treatment interventions not otherwise provided in the CRCF, and protective oversight and supervision to maintain safety in the CRCF.

This service should not be used as a first response to aggression or to an increase in emotional dysregulation by the member, but only when all other clinical and medical interventions have been exhausted. Brief hospitalizations for medication management and behavioral stabilization are not grounds for seeking this level of care. This service is not intended as a general supplement to the day-to-day staffing needs of the provider and must be used only for the authorized member.

C. ID/DD and MH CRFCs must provide active behavioral health treatment, including all the following:

1. Assessment completed in accordance with Section 97.07-3 (A);
2. Behavioral and/or rehabilitative therapies with the specific modality(ies) described in the member's ITP. Therapy must include a minimum of four (4) hours per month for each of the following modalities (unless clinically contraindicated with supporting evidence that is clearly documented in the member's record):
 - a. Individual Therapy, four (4) hours monthly;
 - b. Group Treatment, four (4) hours monthly; and
 - c. Family Therapy, four (4) hours monthly.

Individual and family therapy is conducted by a Clinician (97.01-4) and is in addition to any family visits or meetings. Group treatment is conducted by Professional Staff (97.07-2(A)) and/or Other Qualified Children's Residential Care Facility Staff (97.07-2(H)) and may include therapeutic, educational, or skills-based approaches.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

3. The CRCF must clearly document efforts at engaging the family in treatment and any barriers to family involvement, including any barriers to in person family therapy.

In situations where all reasonable attempts to engage the youth's family have been unsuccessful (at least five (5) distinct attempts using multiple engagement strategies over the course of 1-2 months), providers must contact the Office of Child and Family Services to discuss the situation and options. Providers may be asked to participate in follow-up activities, including the development of a plan as outlined by the Department. A continued lack of family engagement in treatment may result in the youth being discharged from services.

4. For members in ID/DD CRCFs, active treatment may also include behavioral interventions using principles of Applied Behavior Analysis (ABA) as provided by qualified staff. Providers utilizing ABA models shall participate with the Department in fidelity monitoring according to the Department determined process.

ID/DD and MH CRCF providers, under Appendix D of this Section, must additionally meet the following requirements:

- D. **Comprehensive and individualized discharge planning** to include the following:
 1. Active involvement and input from the member and their family or legal guardian;
 2. Referral to Targeted Case Management (Ch. II, Section 13) or Behavioral Health Home (Ch. II, Section 92), if the member is not already receiving these services, and with the member's consent, or in the case of a minor member, consent from the member's parent or legal guardian;
 3. At least thirty (30) days prior to planned discharge date, the provider shall convene a preliminary discharge planning meeting to include at minimum the member, the member's parent or legal guardian, the CRCF clinician, DHHS staff (as applicable), a representative of the member's Targeted Case Management or Behavioral Health Home provider as applicable, and any community service providers who will serve the member following discharge;
 4. At least two (2) days prior to the planned discharge date, the provider will convene a discharge meeting to include the following at

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

minimum: the FTS, the youth, family or legal guardian, community-based provider(s), DHHS Staff (as applicable), Guardian Ad Litem (GAL) (as applicable), and the youth or families chosen professional or informal advocate. The written discharge plan will be provided to all parties at this meeting; and

5. Medications will be ordered three (3) to five (5) days prior to discharge to mitigate medical concerns or medication related questions.
- E. **Crisis planning and intervention** to include development of a written crisis and safety plan;
- F. **Development of a Positive Behavior Support Plan (PBSP)** as described in 97.01-13; and
- G. **Aftercare Support Services** as described in 97.01-1, to include the following:
 1. The CRCF Family Transition Specialist (FTS) is assigned to a youth's case thirty (30) days prior to the youth exiting the services of the provider.
 2. Within seventy-two (72) hours of discharge, the FTS will have in person contact with the client and their family (including siblings as applicable), foster parent, or other placement provider.
 3. Within the first seven (7) days following discharge, the CRCF nurse (RN or APRN-PMH-NP), will contact the member's parent or legal guardian to follow-up on any medical concerns or needs.
 4. The FTS will have contact with the member and their family, including any of the member's siblings (as applicable), to follow-up on the member's status, assess any needs, and provide support. The FTS contact must minimally occur:
 - a. one (1) time per week, (1) to three (3) months post-discharge;
 - b. two (2) times per month, three (3) to six (6) months post-discharge; and
 - c. one (1) time per month in person contact, one (1) to six (6) months post-discharge.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

5. The Family Transition Specialist shall complete a residential Aftercare Support Services summary at thirty (30), ninety (90) and one-hundred eighty (180) days after a youth's discharge from the facility. All summary reports must include any clinical assessments and treatment goals. The reports are due no more than fifteen (15) days after completion to the following, as applicable: child welfare or juvenile justice representative(s), guardian(s), case manager, primary care physician, and/or treatment providers.
6. Exemptions to Aftercare Support Services may be allowable under certain circumstances. Requests for an exemption should be directed to OCFS and must include documentation of supporting evidence that Aftercare Support Services are not medically necessary or clinically contraindicated.

H. Additional Treatment Standards for ID/DD and MH CRCF providers

In addition to the requirements detailed above, providers shall ensure family-centered practices that adhere to the following standards of treatment:

1. The treatment shall be tailored to return the member to a family setting, when possible, and to a community-based setting. The provider shall include and support family members as extensively as possible from the beginning of the admissions process through discharge, transition and aftercare. Providers must make every effort to include families as full partners in all aspects of the member's treatment, barring any limitations on participation. The focus of treatment shall be on helping families acquire the skills necessary to solve problems, meet needs, and attain desired goals. Individualized Family Therapy goals shall be included in the ITP.
 - It is the responsibility of the provider to work with the member and their family to continually pursue effective levels of engagement with families, which include extended family members and natural/informal supports.
2. The treatment shall include planning with families to mobilize both informal and formal resources in support of families. Informal/natural supports include identification of the member and family's personal resources including their specific skills, capacities, or attributes.

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

3. The treatment team shall address family readiness and the specific supports needed to ensure placement stability and success.
4. The CRCF provider will have family-centered policies and procedures that outline the expectations of family treatment and daily living participation. Additionally, policies and procedures shall define exceptions when limits are placed on family participation, including but not limited to protecting the member's welfare as a result of a protection from abuse or other court order, or a member age 18 years and older, or an emancipated minor who does not consent to family participation. Additional components include:
 - a. Ensuring family involvement in all aspects of the services (medical appointments, school communication, daily living, daily programming, etc.); and
 - b. Illustrating the family's right to visitation and treatment participation in the CRCF setting.
5. The CRCF provider will support the parent/guardian accessing treatment interventions including psycho-educational, preventive, and supportive services as indicated by assessments. The focus will be on enhancing the parent/guardian's coping mechanisms by providing them with the tools to move towards self-sufficiency through participation in parenting activities including involvement in positive behavioral supports and management techniques. The provider shall actively involve parents/guardians by providing ongoing opportunities for engagement in the daily life activities of the member in the CRCF setting. Sibling involvement in treatment, visitation, and shared activities must be considered part of the family treatment.
6. The CRFC must maintain documentation of parent/caregiver and family involvement and participation in treatment (to include siblings as appropriate) in the member's record. It is the responsibility of the CRCF provider to document attempts and strategies for family engagement and to overcome barriers to family participation in treatment.
7. Behavioral Support and Management Standards for members receiving services in ID/DD CRCFs:
 - a. The CRCF must complete a Positive Behavior Support Plan (PBSP) that includes strategies and interventions designed to modify interfering behavior. The PBSP must be individualized, respectful, developmentally appropriate,

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

focused on positive reinforcement of desired behavior, and designed to help the child master age and developmentally appropriate skills.

- b. All individualized PBSPs must be based on a Functional Behavioral Assessment (FBA) in accordance with 97.01-6 and completed by a BCBA.
- c. All individual PBSPs must be monitored, reviewed, and adjusted based on the member's behavior and response to treatment and not limited to the required thirty (30) day ITP review.
- d. Each PBSP must include strategies that encourage the use of adaptive and pro-social behaviors with the goal of preventing and/or de-escalating aggressive behavior.
- e. The member's trauma history must be considered in determining the most effective means to de-escalate behavior.
- f. Behavioral interventions must not be used as punishment, a form of discipline, or for the convenience of staff.

I. Physical Care

The population served by children's residential care facilities tends to manifest a wide variety of physical problems in addition to those mental health or behavioral disorders that are the primary presenting problems. For this reason, it is imperative that the provider provides physical care for members that is integral rather than adjunctive. In this sense, the provider shall assure that physical care exists that meets the primary care needs of members. The provider shall coordinate and collaborate with other physical health care providers to assure the appropriate treatment of physical illness and the maintenance of good general health among members. The provider shall also maintain arrangements with external clinicians and facilities for the provision of specialized medical, surgical, and dental services to members.

97.08-3 Community Residences for Persons with Mental Illness

Direct member services performed by clinical personnel refers to mental health treatment, substance use treatment, rehabilitative services and/or personal care services performed as deemed medically necessary and described in an authorized plan of care with the member present and participating. These services

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

are provided within the scope of their licensure or certification by Clinicians (as defined in 97.01-4), occupational therapists, other qualified mental health staff, personal care service staff, or other qualified alcohol and drug treatment staff as defined in Chapter II, Section 97.07-2.

Mental health treatment and rehabilitative services refer to direct member services provided for the reduction of mental illness symptoms and restoration of a member to his/her best possible functional level. These services focus on the establishing or regaining of functional skills; the increase of self-understanding, crisis prevention and self-management; socialization and leisure skill development; the development and enhancement of social roles within the context of natural supports, the consumer's community, and others within the residential treatment facility; and other activities connected with the rehabilitation goals and objectives identified in the plan of care.

These services are deemed medically necessary and described in an authorized plan of care and are provided with the member present and participating. The individualized rehabilitation plan shall include sequential steps developed with the consumer. Treatment planning will include, when possible, community staff providing services outside the facility as well as residential treatment facility staff. Planning will also include any other individuals that the member chooses. The plan will reflect individualized goals and objectives identifying the tailored services to be provided. Services provided are based on a well-defined, time-limited plan that focuses on the member's strengths, needs, and choices which is developed through a regularly scheduled, individualized planning process on a quarterly basis. One of the key elements reflected in the services provided by the facility is that of the expectation of growth and recovery. Mental health treatment and rehabilitative services are provided by Clinicians (as defined in 97.01-4), certified interpreters, occupational therapists, and other qualified mental health staff, as defined in Chapter II, Section 97.07-2, operating within their competence in accordance with state law.

MaineCare does not cover personal care services provided by a family member. Personal care services must be prescribed by a physician, are provided by other qualified mental health staff, in accordance with their respective plans of care, as defined in Section 97.07-2 (E) and include, but are not limited to, the following:

- Assistance or supervision of activities of daily living including bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks essential to the activities of daily living and to the maintenance of the member's health and safety;

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- Supervision of or assistance with administration of physician-ordered medication;
- Personal supervision or being aware of the member's general whereabouts, observing or monitoring the member to ensure their health and safety, reminding the member to carry out activities of daily living, and assisting the member in adjusting to the facility and the community;
- Arranging transportation and making phone calls for appointments as recommended by medical providers or as indicated in the member's plan of care; and
- Observing and monitoring member's behavior and reporting changes in the member's normal appearance, behavior, or state of health to medical providers or supervisory personnel as appropriate.

Integrated treatment services for persons with coexisting disorders (chronic mental illness and substance use) shall include mental health and substance use rehabilitative services. These services teach skills and habits conducive to lifestyle choices which reduce risk and foster successful long-term recovery. Such rehabilitation services include individual counseling, family therapy, group therapy, and other services necessary to enhance a member's successful transition to housing and services in the community and promote the ability to function as independently as possible in the community.

Integrated treatment services shall also include independent living skills and social skills services, necessary to promote ongoing recovery and treatment. Specific treatment goals and objectives of such services shall be documented in each member's individual service plan.

MaineCare does not reimburse for services that are primarily academic, vocational, socialization or recreational in nature, as described in Chapter I of the *MaineCare Benefits Manual*. MaineCare does not reimburse self-help supportive meetings.

A. Description of the Facility's Clinical Services

Clinical responsibility for implementation of each member's individual service plan shall rest with a licensed or certified mental health professional operating within the scope of his/her license or certification under Maine law. Such mental health professional shall be responsible for the provision of direct services and for documented supervision of other qualified mental health staff involved in implementing the service plan. The Department, in accordance with its licensing and certification regulations, must approve supervisory arrangements. The mental health

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

professional may be employed by the facility or engaged through a consultant contract or agreement.

Within thirty (30) days of the entry of the member in the facility, all services must be provided pursuant to a written service plan based on an individualized assessment of the member made by a Clinician (as defined in 97.01-4). The plan shall specify the treatment and rehabilitative services to be provided at the facility site. The plan shall be reviewed and documented every ninety (90) days.

Records must be maintained and reviewed in accordance with Sections 97.07-4, 5, and 7. Progress notes must be entered into the record and signed at least daily, at a minimum addressing specific goals indicated in the individual treatment plan.

Only services provided at the facility for the diagnosis, assessment, treatment, rehabilitation, or provision of personal care services are reimbursable. It is recognized that many elements of a comprehensive plan of services to members with mental illness are not reimbursable by MaineCare. Services reimbursable under Section 97, Chapter III may complement, but must not duplicate, services provided outside of the facility, regardless of the actual provider of services. Each member's comprehensive individual service plan shall assure the most appropriate non-duplicative mix of services.

B. Personal care services

PNMIs approved and funded by Office of Behavioral Health in licensed facilities must also provide personal care services necessary for the promotion of ongoing treatment and recovery.

97.08-4 Medical and Remedial Facilities

Medical and remedial facilities, whether they are case-mix reimbursed or non-case mix reimbursed facilities, include services provided at the facility for the diagnosis, assessment, treatment, rehabilitation, or provision of personal care services. These services must be provided within the scope of licensure or certification by staff as defined in Section 97.07-2.

MaineCare does not cover personal care services provided by a family member. A physician must prescribe personal care services. Other qualified personal care staff must provide services in accordance with respective plans of care, which include, but are not limited to, the following:

- Provision of personal care and nursing services;

97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)

- Assistance with or supervision of activities of daily living including bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks such as food preparation, laundry, and housekeeping essential to the activities of daily living and to the maintenance of the member's health and safety;
- Supervision of or assistance with the administration of physician-ordered medication;
- Personally supervising or being aware of the member's general whereabouts, observing or monitoring the member to ensure his or her health and safety, reminding the member to carry out activities of daily living, and assisting the member in adjusting to the facility and the community; and
- Arranging transportation for appointments as recommended by medical providers or as indicated in the member's plan of care.

97.09 REIMBURSEMENT

For each MaineCare provider enrolled as a participating Private Non-Medical Institution, the Department will determine an interim per diem rate, as determined under Chapter III, Section 97, Principles of Reimbursement for Private Non-Medical Institution Services, and the applicable Appendix.

Providers are required to obtain separate MaineCare provider number(s) for each PNMI provider type as described in Section 97.01-15. Upon completion of the provider's fiscal year, the providers shall submit to the Department, a cost report for each PNMI that has been assigned a provider number(s) in accordance with Chapter III of the Principles of Reimbursement.

Agencies that obtain public funds from another source to use as either a portion or as the entire State share of the PNMI rate must complete a Rider A as part of their Provider/Supplier Agreement to certify the State share of MaineCare funding. If certified public funds support only a portion of the PNMI rate, the full rate must be paid to the provider, with an adjustment made at settlement to reimburse the Department the amount certified in Rider A. This amount will be reported to the Department using Chapter III, Section 97 rules for the submission of cost reports.

In accordance with Chapter I of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare.

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97.10 BILLING INFORMATION

Providers must bill in accordance with the Department's billing Instructions for the UB-04 Claim Form. Billing instructions are available at:

<https://mainecare.maine.gov/Billing%20Instructions/Forms/Publication.aspx>

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Table I
Qualifying Diagnoses

Category	Diagnosis	ICD-10
Schizophrenia Spectrum	Schizophrenia	F20.9
Moderate and Severe Modifier	Paranoid schizophrenia	F20.0
	Disorganized schizophrenia	F20.1
	Catatonic schizophrenia	F20.2
	Undifferentiated schizophrenia	F20.3
	Residual schizophrenia	F20.5
	Schizophreniform disorder	F20.81
	Schizoaffective disorder, bi-polar type	F25.0
	Schizoaffective disorder, depressive type	F25.1
	Other Schizoaffective disorders	F25.8
Bipolar and Related Disorders	Bipolar I disorder, current episode manic w/out psychotic features,	F31.12
	Bipolar I disorder, current episode manic w/out psychotic features, severe	F31.13
	Bipolar I disorder, current episode manic, severe with psychotic features	F31.2
	Bipolar I disorder, current episode depressed, moderate	F31.32
	Bipolar I disorder, current episode depressed, severe, w/out psychotic	F31.4
	Bipolar I disorder, current episode depressed, severe, with psychotic	F31.5
	Bipolar I disorder, current episode mixed, moderate	F31.62
	Bipolar I disorder, current episode mixed, severe, w/out psychotic features	F31.63
	Bipolar I disorder, current episode mixed, severe, with psychotic features	F31.64
	Bipolar I disorder in partial remission, most recent episode manic	F31.73
	Bipolar I disorder, in partial remission, most recent episode depressed	F31.75
	Bipolar I disorder, in partial remission, most recent episode mixed	F31.77
	Bipolar II disorder	F31.81
	Other bipolar disorder	F31.89
	Cyclothymic Disorder	F34.0
Depressive Disorders	Major depressive disorder, single episode, moderate	F32.1
	Major depressive disorder, single episode, severe w/out psychotic features	F32.2
	Major depressive disorder, single episode, severe with psychotic features	F32.3
	Major depressive disorder, single episode, in partial remission	F32.4
	Major depressive disorder, recurrent, moderate	F33.1
	Major depressive disorder, recurrent, severe w/out psychotic symptoms	F33.2
	Major depressive disorder, recurrent, severe, with psychotic symptoms	F33.3
	Major depressive disorder, recurrent, in partial remission	F33.41
	Disruptive mood dysregulation disorder	F34.8
Anxiety Disorders	Panic Disorder	F41.0
	Generalized anxiety disorder	F41.1
Personality Disorder	Borderline Personality Disorder	
Trauma and Stressor Related Disorders	Posttraumatic stress disorder	F43.10
	Posttraumatic stress disorder, acute	F43.11
	Posttraumatic stress disorder, chronic	F43.12
Dissociative Disorder	Dissociative identity disorder	F44.81
Disruptive, Impulse-Control, and Conduct	Oppositional defiant disorder	F91.3
	Intermittent Explosive Disorder	F63.81
Neurodevelopmental Disorders	Attention Deficit Hyperactivity Disorders	F90-